

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

### 1. PLACE OF DEATH

County Baltimore  
City or town Bridgewood  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 3/4 yrs  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County Baltimore  
City or town Bridgewood  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 907 St Charles Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Barrie L. Adams

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed.

6.(b) Name of husband or wife George Adams

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) (Unknown) 1876

8. AGE: Years 72 Months Germany Days (Town, county, and state) If less than one day Housework.

9. Birthplace Germany

10. Usual occupation Housework.

11. Industry or business

12. Name Koellner

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mrs Frances Becker

Address 407 St Charles Ave

17. (Burial, cremation, or removal, Which?) Burial Date thereof Aug 18 1948

(month) (day) (year)

Cemetery or crematory Baltimore

Location Baltimore Md

18. Funeral director Dill Bros.

Address 3109 Frederick Ave

19. 8/9 48 Dr

(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 6, 19 48 at 10<sup>35</sup> P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 30 June 19 48 to 6 August 19 48

and that I last saw her alive on 6 August 19 48

Immediate cause of death Generalized Carcinomatosis

Due to Carcinoma left Breast DURATION 8 mos

Due to 1 year

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edward L. J. Krieg MD

M. D. or other

Address 821 N. Chapel Gate Lane Date signed 7 Aug 48

Balto - 29 - Md

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1876

72

1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County BaltimoreCity or town Anneslie  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
Armecost Nursing Home - 812 Register Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County .....City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1903 Homewood Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

ELIZABETH ALBAUGH

## 3. (b) Social Security Number

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>
-------------------------	----------------------------------	--

6. (b) Name of husband or wife H. Aaron Albaugh7. Birth date of deceased (mo., day, yr.) October 27, 1871

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>9</u>	<u>25</u>	..... hrs. .... min.

9. Birthplace Glen Rock, Penna.  
(Town, county, and state)10. Usual occupation Seamstress11. Industry or business Hutzler Brothers Co.12. Name Conrad Gable13. Birthplace Germany14. Maiden name Barbara Zeiler15. Birthplace U.S.A.16. Informant Charles C. GieseyAddress 1903 Homewood Avenue17. Burial Date thereof August 25, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Loudon ParkLocation Baltimore, Maryland18. Funeral director William Cook, Inc.Address 1217 St. Paul Street19. 8/24 19 48 A.W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 19 48 at 4:10 A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 46 to Aug 22 19 48  
and that I last saw her alive on Aug 21 19 48Immediate cause of death Coronary occlusion DURATION 5 daysDue to Myocardial Infarction 1 yrDue to Arterio-sclerosis 5 yrs

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE Norman E. Todd M.D. M. D. or otherAddress 2108 St Paul St Date signed 8/23/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

241F N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mount Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 0 yrs., 3 mos., 11 days  
 Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. T. B. Sanatorium  
 How long in hospital or institution? 0 yrs., 3 mos., 11 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Howard  
 City or town Ellicott City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. St. John's Lane  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Miss Madge M. Allen

## 3. (b) Social Security Number

# Unknown

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 8. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

## 7. Birth date of deceased (mo., day, yr.)

December 15, 1911

## 8. AGE:

Years

Months

Days

If less than one day

36

8

0

hrs.

min.

## 9. Birthplace.....

Fruitland, Idaho  
(Town, county, and state)

## 10. Usual occupation.....

Housework

## 11. Industry or business.....

FATHER  
MOTHER

## 12. Name.....

Clyde J. Allen

## 13. Birthplace.....

Tennessee

## 14. Maiden name.....

Flora Allen

## 15. Birthplace.....

White Cloud, Kansas

## 16. Informant.....

Mrs. C. Allen, Mother

## Address.....

St. John's Lane, Ellicott City, Md.

## 17. Removal.....

(Burial, cremation, or removal. Which?)

Date thereof. Burial-8/18/48  
(month) (day) (year)

## Cemetery or crematory.....

Shank Cemetery

## Location.....

Rogersville, Tenn.

## 18. Funeral director.....

F. C. Higinbotham

## Address.....

Ellicott City, Md.

## 19. Aug. 15, 1948

(Date rec'd by registrar)

Helen R. Mayer  
R. E. Nichols Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1948 at 9:40 A.21. I CERTIFY that death occurred on the date above related; that I attended deceased from May 4, 1948 to Aug. 15, 1948 and that I last saw her alive on August 15, 1948

## Immediate cause of death.....

Pulmonary Tuberculosis

## DURATION

14 yrs.Due to Tubercle Bacilli

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations No operation.

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Stewart S. Shaffer MD.  
M. D. of otherAddress Mt. Wilson, Md. Date signed 8/15/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

## 1. PLACE OF DEATH:

County BaltimoreCity or town Cockeysville Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 yrs. 9 Months

Hospital, institution, or street address where death occurred:

Masonic Home, Cockeysville Md

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County \_\_\_\_\_City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1707 E. Lansdale St  
(If rural, give LOCATION)2.(a) If veteran, name war \_\_\_\_\_ ☒

## 3. (a) FULL NAME

Mrs Louise Armiger

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow6.(b) Name of husband or wife Frank Armiger7. Birth date of deceased (mo., day, yr.) Sept. 29 - 1870

6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 77 Months 10 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Baltimore Md  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name John Kern13. Birthplace Germany14. Maiden name Catherine Reichert15. Birthplace Germany16. Informant Laura M. SchroederAddress Masonic Home, Cockeysville Md17. Burial Date thereof 8-12-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore CemeteryLocation Gift to Husband18. Funeral director Wm. CookAddress St. Paul & Preston St19. 8-10- 19 48 Laura M. Schroeder  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 19 48 at 4:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 19 47 to Aug 10 19 48and that I last saw her alive on Aug 9 19 48

Immediate cause of death

Heart Failure

DURATION

Due to AtherosclerosisDue to HypertensionOther conditions Pagets DiseaseRumpled Chest

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE

Walter T. Kees M.D.  
Address Cockeysville Md. Date signed 8/10/48

RECEIVED

AUG 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of the information is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Essex 21 Balto  
 City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 27 Walkerton Rd.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

LUTHER

BASS

## 3. (b) Social Security Number

242-01-3281

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Maudie

## 7. Birth date of deceased (mo., day, yr.)

1-15-1913

## 6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

63

hrs.

min.

## 9. Birthplace

M. C.

(Town, county, and state)

## 10. Usual occupation

Ticket man

## 11. Industry or business

Midway Theatre

MOTHER FATHER

## 12. Name

Edward Bass

## 13. Birthplace

M. C.

## 14. Maiden name

Ellen Travick

## 15. Birthplace

M. C.

## 16. Informant

Maudie Bass

## Address

27 Walkerton Rd.

## 17. (Burial, cremation, or removal, Which)

Burial

## Date thereof

Aug 31/48

## Cemetery or crematory

Oak Lawn

## Location

Green

## 18. Funeral director

J. Brydzinski

## Address

1407 Eastern Ave Rd.

## 19. (Date rec'd by registrar)

Aug 31 19 48

## 20. (Date rec'd by registrar)

9. W. Hedrick

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

8/28 48 at 5:58 PM

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11/22/

19 47 to

8/28 19 48

and that I last saw him alive on

8/28 19 48

## Immediate cause of death

Cerebral Thrombosis

## DURATION

1 day

## Due to

Hypertension Cerebro-vascular disease

## Due to

## Other condition

Psychosis due to cerebral arteriosclerosis.  
(Include pregnancy within 3 months of death)

3 years

## Major findings of operations

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

M. D. or other

Address

Spring Grove Hosp.

Date signed 8/28/48

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4X

### 1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Approximately 4 Hrs.  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Maryland  
How long in hospital or institution? Approximately 4 Hrs.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 313 S. Parrish Street  
(If rural, give LOCATION)  
2. (a) If veteran, name war WW I

### 3. (a) FULL NAME

FRANK H. BEALES

### 3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of deceased's wife Margaret Beales

6. (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) 11-20-89

8. AGE: Years 58 Months 8 Days 21 If less than one day hrs. min.

9. Birthplace Tyrone, Pa.  
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

12. Name Blair Beales

13. Birthplace Unknown

14. Maiden name Annie Bell

15. Birthplace Tyrone, Pa.

16. Informant Clinical Records, Vets. Adm. Hosp.  
Address Fort Howard, Maryland

17. Burial Date thereof 8/16/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Baltimore National Cemetery  
Baltimore, Md.

18. Funeral director John J. Cowan & Son  
Address Baltimore, Md.

19. 8/13 19 48 H. C. Managh  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 11, 1948 at 9:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11, 1948 to August 11, 1948 and that I last saw him alive on August 11, 1948

Immediate cause of death Syphilitic Cardiovascular disease, Since  
Cardiac Hypertrophy, decompensation Jan. 2, 1947

Other conditions Aneurysm, Aorta (Arch and Descending), Syphilitic  
(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results None  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide None Date of None  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE H. C. Managh  
H. C. MANAGH, M.D. Chief of M. D. Ser.  
Address None Date signed None

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

He pr  
30d

08073

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

## 1. PLACE OF DEATH:

County BaltimoreCity or town Owings Mills  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 yrs 9 mos

Hospital, institution, or street address where death occurred:

Rosewood State Training SchoolHow long in hospital or institution? 12 yrs 9 mos

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Owings Mills  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Louise Beavers

## 3. (b) Social Security Number

4. Sex F5. Color or race W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) July 1, 19128. AGE: Years 36 Months 1 Days 12 It less than one day

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Gettysburg, Montgomery, Md.  
(Town, county, and state)10. Usual occupation Inmate of Institution

11. Industry or business \_\_\_\_\_

12. Name William Beavers13. Birthplace Montgomery County, Md.14. Maiden name Rebecca Butt15. Birthplace Montgomery County, Md.16. Informant Institution RecordsAddress Rosewood, Owings Mills Md17. Burial Date thereof Aug 13, 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rosewood CemeteryLocation Balto. Co.18. Funeral director J. F. Elmer SonsAddress Prestertown Md.19. Aug-13-1948 Mary B. Elmer  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 19 48 at 1:35 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26 19 48 to August 12 19 48and that I last saw him alive on August 12 19 48

Immediate cause of death \_\_\_\_\_

Acute Pulmonary Edema

## DURATION

6 hrsDue to Round Cell Sarcoma ofCervical Tissue Reticular

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations Round Cell SarcomaDate of op. May 8, 1948Autopsy results Not yet reported

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Violet B. Johns, A.M. M.D.

M. D. or other

Address Rosewood, Owings Mills Md. Date signed 8/12/48



CERTIFICATE OF DEATH

RECEIVED

AUG 17 1948

BUREAU V. S.

## FEDERAL SECURITY AGENCY

Public Health Service

National Office of Vital Statistics

Form Approved

Budget Bureau No. 68-R275

VS: 76(45)

Dr. Viola B. Johns  
Rosewood St. Training School  
Owings Mills, Maryland

## SECOND REQUEST

October 4, 1948

NOV 9 1948

Dear Dr. Johns:

In order to classify intelligently causes of death it is essential that we have the most specific information obtainable. We therefore request that you supply this bureau with the following additional information regarding the cause of death of

Name

Louise Beavers

Who died at Owings Mills, Baltimore County on August 12, 1948.

The cause of death is given as follows:

Acute Pulmonary Edema  
Round Cell Sarcoma of Cerebrum  
Frente Parietal Area

Major findings of operations--Round Cell Sarcoma, Date-May 8, 1948  
Autopsy results---Not yet reported

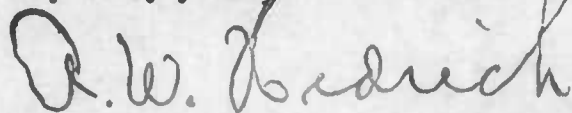
What were the findings of the autopsy?

The examination of this brain is still incomplete. It is being done at the Pathology Department of the University of Maryland - as you know, it is necessary that these specimens be hardened before examination and the process requires some time. You might ask Dr. Alvey of the Dept. of Pathology, University of Maryland School of Medicine, Lombard and Greene Sts. Baltimore, Maryland for his findings - I called him upon re-

Signature of Informant \_\_\_\_\_

The information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed envelope which requires no postage.

Very truly yours,



Special Agent, Public Health Service  
State Department of Health  
Baltimore, Maryland

ceiving your request and he has indicated willingness to report as soon as examination is completed.

Viola B. Johns, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County **Baltimore**  
 City or town **Catonsville 28, Maryland**  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death **9 days**

Hospital, institution, or street address where death occurred:

**Spring Grove State Hospital**How long in hospital or institution? **9 days**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland** County **Baltimore**  
 City or town **Catonsville 28, Maryland**  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. **37 Nunnery Lane**

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

**MARIE S. BELT**

## 3. (b) Social Security Number

## 4. Sex

**female**

## 5. Color or race

**white**

## 6. (a) Single, married, widowed, or divorced

**married**

## 6. (b) Name of husband or wife

**Walter S. Belt**

## 7. Birth date of deceased (mo., day, yr.)

**January 16, 1890**8. (c) If alive, give age **59** years

## 8. AGE:

Years

Months

Days

If less than one day

**58****7****7**

hrs.

min.

## 9. Birthplace

**Virginia**

(Town, county, and state)

## 10. Usual occupation

**housewife**

## 11. Industry or business

**domestic**

## MOTHER

## 12. Name

**Emmanuel Pace**

## 13. Birthplace

**Virginia**

## 14. Maiden name

**? White**

## 15. Birthplace

**Virginia**

## 16. Informant

**Hospital Records**

## Address

**Catonsville 28, Maryland**

## 17.

**BURIAL**Date thereof **AUG 25 '48**  
(month) (day) (year)

## Cemetery or crematory

**GLEN HAVEN**

## Location

**GLEN BURNIE MD**

## 18. Funeral director

**Henry H. Witzke**

## Address

**4101 Elmwood Ave**

## 19.

**8-24**

19

**48****VE Harry**

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH **August 23, 1948** at **12:15 p.m.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

**August 14, 1948** to **August 23, 1948**and that I last saw her alive on **August 23, 1948**

Immediate cause of death

**Right lower lobar pneumonia**

DURATION

**36 hours**Due to **Myocardial insufficiency****24 hours**

Due to

Other conditions **Old comminuted fracture, right hip with non-union****indef.**

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

**none**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

**Isadore Tuerk, M.D.**

23. SIGNATURE

**Catonsville-28, Md.**

M. D. or other

**8-23-48**

Address Date signed

RECEIVED

AUG 26 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 207 Days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Md.  
 How long in hospital or institution? 207 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County   
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 804 E. Lombard Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

WILLIAM BIVONS

## 3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife Widower  
 6. (c) If alive, give age  years

7. Birth date of deceased (mo., day, yr.) 9-19-92  
 8. AGE: Years 55 Months 11 Days 6  
 If less than one day  hrs.  min.

9. Birthplace Virginia  
 (Town, county, and state)

10. Usual occupation Chauffeur

11. Industry or business

FATHER 12. Name Calvin Bivons  
 13. Birthplace Virginia

MOTHER 14. Maiden name Missouri Giddens  
 15. Birthplace Virginia

16. Informant Clinical Records, Vets. Adm. Hosp.  
 Address Fort Howard, Maryland

17. Burial Baltimore National Cemetery  
 (Burial, cremation, or removal. Which?) Date thereof 8/27/48  
 (month) (day) (year)  
 Cemetery or crematory Baltimore, Md.  
 Location Charles R. Law

18. Funeral director 802 Madison Ave., Balto., Md.  
 Address

19. 8/26/48 19. 48  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 25, 1948 at 4:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31, 1948 to August 25, 1948  
 and that I last saw him alive on August 25, 1948

Immediate cause of death Bronchogenic carcinoma DURATION 2 Yrs.

Due to

Due to

Other conditions none

(Include pregnancy within 8 months of death)

Major findings of operations  Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury  Injured at work?

23. SIGNATURE H. C. MAMAUGH  
H.C. MAMAUGH, M.D. Chief Prov. Sec.  
 Address VAH, Ft. Howard, Md. Date signed 8-25-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 13608077  
1  
449

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 days

Hospital, institution, or street address where death occurred:

Veterans Administration HospitalHow long in hospital or institution? 33 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 921 McDonald Street

(If rural, give LOCATION)

2.(a) If veteran, name war WW I

## 3. (a) FULL NAME

ARTHUR BLACKWELL

## 3. (b) Social Security Number

Unknown

## 4. Sex

Male

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Married - Sep.

## 8. (b) Name of husband or wife

unknown

## 7. Birth date of deceased (mo., day, yr.)

12-12-02

B. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

4582

hrs.

min.

## 9. Birthplace

Baltimore, Maryland

(Town, county, and state)

## 10. Usual occupation

Unemployed

## 11. Industry or business

FATHER

12. Name Archie Blackwell13. Birthplace Virginia

MOTHER

14. Maiden name Unknown15. Birthplace Unknown

## 16. Informant

Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory Baltimore NationalLocation Baltimore, Maryland

## 18. Funeral director

Charles R. LawAddress 802 Madison Ave., Balto., Md.

## 19.

8-17  
(Date rec'd by registrar)

19

48

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1948 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 11 1948 to August 14 1948and that I last saw him alive on August 14 1948Immediate cause of death Pulmonary Tuberculosis

DURATION

2 months  
or more

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

Pulmonary Tuberculosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

D. R. Davis M.D.

M. D. or other

Address V.A. H - Fort HowardDate signed July 24



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

### 1. PLACE OF DEATH:

County Baltimore  
City or town Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Int. Pleasant Sanatorium  
How long in hospital or institution? Since August 3, 1948

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2212 East Fairmount Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

### 3. (a) FULL NAME

Iola Blum

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Benjamin Blum

7. Birth date of deceased (mo., day, yr.) 1872 6. (c) If alive, give age years

8. AGE: Years 76 Months ? Days ? If less than one day hrs. min.

9. Birthplace Russia  
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name Hanken Gofsovitzy

13. Birthplace Poland

14. Maiden name Katie

15. Birthplace Russia

16. Informant Hyman Blum

Address 2603 Loyola Southern

17. Burial Date thereof 8-9-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rosedale

Location Phila Rd Hamlet Ave

18. Funeral director Jack Lewis, Inc

Address 2000 Eutaw Place

19. 8/9 48 W. Hedrick  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1948 at 4:05 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 3, 1948 to August 8, 1948 and that I last saw her alive on August 2, 1948

Immediate cause of death Hypertoid Failure

Due to Congestive Heart Failure DURATION 2 weeks

Due to Pulmonary Tuberculosis DURATION 8 months

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. Pomeroy M. D. or other

Address Reisterstown, Md. Date signed 8/8/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct date is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

### 1. PLACE OF DEATH:

County Baltimore  
City or town Catonsville 28, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 27 days  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 27 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Calvert  
City or town Port Republic, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Calvert County  
(If rural, give LOCATION)

2.(a) If veteran, name war. /

### 3. (a) FULL NAME

SADIE BOND

### 3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Brooke Bond  
6. (c) If alive, give age 72 years  
7. Birth date of deceased (mo., day, yr.) December 20, 1875  
8. AGE: Years 72 Months 7 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Calvert County, Maryland  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business Domestic  
12. Name John W. Peterson  
13. Birthplace Maryland  
14. Maiden name Brooke Dorsey  
15. Birthplace Maryland

16. Informant Hospital Records  
Address Catonsville 28, Maryland

17. Burial Date thereof Aug. 12, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Christ Church  
Location Port Republic, Md

18. Funeral director A. G. Harkness & Son  
Address Mt. Airy, Md

19. 8-11 48 VE Hark  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 10, 1948 at 9:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14, 1948 to August 10, 1948 and that I last saw her alive on August 10, 1948

Immediate cause of death Terminal pneumonia Cerebral hemorrhage, left  
DURATION 72 hours 7 days

Due to Arteriosclerotic heart disease indefinite

Due to Arteriosclerosis, generalized indefinite

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results No Autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Signature Isadore Tuerk, M. D.

23. SIGNATURE \_\_\_\_\_ M. D. or other \_\_\_\_\_

Address Catonsville 28, Md. Date signed 8/10/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**RECEIVED**

AUG 12 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08080

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County **BALTIMORE**  
 City or town **CATONSVILLE 28, MARYLAND**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **16**  
 Hospital, institution, or street address where death occurred:  
**SPRING GROVE STATE HOSPITAL**  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State **Maryland** County  
 City or town **Baltimore, Maryland**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **114 S. Ellwood Avenue**  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

**JOHN BOUTHNER**

## 3. (b) Social Security Number

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, married, widowed, or divorced **MARRIED**  
 6. (b) Name of husband or wife **LENA EIERMANN**  
 7. Birth date of deceased (mo., day, yr.) **AUGUST 15, 1872**  
 B. (c) If alive, give age **64** years  
 8. AGE: Years **76** Months **0** Days **11** If less than one day  
 hrs. min.

9. Birthplace **Maryland**  
 (Town, county, and state)  
 10. Usual occupation **Factory**  
 11. Industry or business  
 12. Name  
 13. Birthplace  
 14. Maiden name  
 15. Birthplace

18. Informant **Hospital Records**  
 Address **Catonsville 28, Maryland**  
 17. **Burial** Date thereof **8/30/48**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory **Mt. Carmel**  
 Location **O'Donnell St.**  
 18. Funeral director **Clarence F. Hoffmann**  
 Address **1639 Broadway.**  
 19. **8/27** 19 **48** **A. W. Hedrick**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH **August 26, 1948** at **8:00a.m.**  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **August 10, 1948** to **August 26, 1948**  
 and that I last saw him alive on **August 26, 1948**  
 Immediate cause of death **Cerebral-vascular accident**  
 DURATION **24 hrs.**  
 Due to **Hypertensive cardiovascular disease, arteriosclerosis** **indef.**  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)  
 Major findings of operations  
 Date of op.  
 Autopsy results **No autopsy**  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury **Stroke** Injured at work?  
 23. SIGNATURE **ISADORE TUERK, M. D.** M. D. or other  
 Address **CATONSVILLE 28, MARYLAND** Date signed **8/26/48**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County Rodgers ForgeCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

409 Dumbarton Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Rodgers ForgeCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 409 Dumbarton Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

GIOVANNIA (JENNIE) BRUNO

## 3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife

Nunzio Bruno7. Birth date of  
deceased (mo., day, yr.)Jan. 25, 1876

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

72613

hrs.

min.

9. Birthplace

Italy

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

FATHER

12. Name

?Lombardo

13. Birthplace

Italy

MOTHER

14. Maiden name

?

15. Birthplace

Italy

16. Informant

Mrs. Lucy Profili

Address

409 Dumbarton Road

17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Holy Redeemer

Location

Baltimore, Md.

18. Funeral director

Leonard J. Ruck

Address

5305 Harford Road #14

19.

(Date registered by registrar)

Aug 9 1948A. W. Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

August 7, 1948 at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 10 1947 to Aug 7 1948  
and that I last saw him alive on August 8, 1948

Immediate cause of death

Carcinoma of sigmoid colon  
Metastatic carcinoma of  
liver

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Samuel B. Wolf, M.D.

M. D. or other

Address

1331 North Ave.Date signed 8-7-48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

## 1. PLACE OF DEATH

County Balto.City or town Sparrows Pt.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7807 N. Carl Rd.  
How long in hospital or institution? 20 yrs.

## 3. (a) FULL NAME

Paul Brunovsky.

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 13-1887  
6. (c) If alive, give age ..... years

8. AGE:

Years 61 Months 11 Days 13 If less than one day ..... hrs. .... min.

9. Birthplace

Czechoslovakia  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Unknown

13. Birthplace

Czechoslovakia

14. Maiden name

15. Birthplace Czechoslovakia

16. Informant

Stephan Sitar  
Address 3613 E. Fayette St17. Burial(Burial, cremation, or removal, Which?) Date thereof 8/12/48  
(month) (day) (year)Cemetery or crematory Balto National CemLocation Balto.

18. Funeral director

Wm Cook Inc.  
Address 21257 Dunc Street19. 8/7

(Date recd by registrar)

19. 48N-10 Hedrick  
RW Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... County .....

City or town .....  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2. (a) If veteran, name war .....

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1948 at 1:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 18 ..... to ..... 19 .....

and that I last saw him alive on ..... 19 .....

Immediate cause of death

Coronary thrombosis

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings at operations .....

..... Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE

Dr. Carmine M.D.  
Address Balto Co. Dundalk 87548

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltoCity or town Essex  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

625 Franklin Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltoCity or town Essex  
(If outside city or town limits, write RURAL and give nearest town)Street No. 625 Franklin Ave  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Anna Elizabeth Burkentine

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widow, or divorced

married

8. (b) Name of husband or wife

Paul Burkentine

7. Birth date of

deceased (mo., day, yr.)

Apr. 25-1894

6. (c) If alive, give age years

8. AGE:

Years

54

Months

3

Days

If less than one day

hrs.

min.

9. Birthplace

Belair Harford Co., Md  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

at home

FATHER

12. Name

Henry Campbell

13. Birthplace

Cecil Co., Md

MOTHER

14. Maiden name

Mary Asher

15. Birthplace

Harford Co. Md

16. Informant

Mr. Paul Burkentine

Address

625 Franklin Ave.

17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Burial  
Moreland Park Cem.

Location

Saylor, Ave

18. Funeral director

John G. Connolly

Address

418 E Eastern Ave.

19.

(Date rec'd by registrar)

19

8/10/48  
John G. Connolly

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 19 48 at 10:38 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 4 19 48 to Aug. 9 19 48and that I last saw him alive on Aug. 9 19 48

Immediate cause of death

Cachexia

DURATION

1 mo

Due to

Generalized abdominal metastases 5 mo

Due to

Carcinoma ovary 8 mo

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Carcinomatosisabdomen

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

John G. Connolly  
418 E Eastern Ave Date signed 8/9/48

M. D. or other

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 34 days  
 Hospital, institution, or street address where death occurred:  
Veterans Administration Hospital  
 How long in hospital or institution? 34 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Talbot  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 424 South Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WW I

## 3. (a) FULL NAME

FRANK BURROWS

## 3. (b) Social Security Number

214-12-6204

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mrs Frank Burrows  
 6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 6-5-90  
 8. AGE: Years 58 Months 2 Days 9 if less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Easton, Md.  
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

12. Name West Burrows  
 13. Birthplace Eston, Md.

14. Maiden name Williw Dickerson  
 15. Birthplace Easton, Md.

16. Informant Clinical Records, Vets. Adm. Hospital  
 Address Fort Howard, Md.

17. Burial Date thereof 8/17/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_  
 Location Easton, Maryland

18. Funeral director Charles R. Law  
 Address 802 Madison Avenue

19. 8-17-48 22  
 (Date signed by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 19 48 at 2:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 19 48 to August 15 19 48

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Carcinoma of bladder and Prostate DURATION Unknown

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Paul Padgett M.D. or other \_\_\_\_\_

PAUL PADGETT, M.D. Act. Chief, Pro. Ser.  
 Address VAH, Ft. Howard, Md. Date signed 8-16-48

Evidence for addition of  
items 8,9, & 11 shown

MARYLAND STATE DEPARTMENT OF HEALTH

on:

2411 N. Charles Street, Baltimore

FILM No. G 118 JAN 17 1949

CERTIFICATE OF DEATH

025

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>417 Parksley Avenue</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>GLENN</u> <u>CLARK</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>August 31, 1948</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 12, 1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	9. AGE last birthday (If under 1 year Months Days Hours Min.) <u>50</u> yrs. <u>8</u> Months <u>19</u> Days
11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co., Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George W. Clark</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Ward</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Hospital Records</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cachexia</u>		<u>1 year</u>
Antecedent cause(s) (b) <u>Decubitus ulcers, back and knees</u>		<u>3 months</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Tubo-paresis</u>		<u>years</u>

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1940, to August 31, 1948, that I last saw the deceased alive on August 31, 1948, and that death occurred at 5 a.m., from the causes and on the date stated above.

SIGNATURE Isadore J. Jurek, M.D. ADDRESS Catonsville 28, Md. DATE SIGNED 1/10/49

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>1-11-49</u>	NAME OF CEMETERY OR CREMATORY <u>Spring Grove State Hospital</u>	LOCATION (City, town, or county) (State) <u>Catonsville 28, Md.</u>
DATE REC'D BY LOCAL REG. <u>1-11-49</u>	REGISTRAR'S SIGNATURE <u>T.E. Harry</u>	24. FUNERAL DIRECTOR <u>Spring Grove State Hospital, Balto. 28, Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. 415

RECEIVED

JAN 13 1949

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 47

1. PLACE OF DEATH:  
 County... Baltimore  
 City or town... Victory Villa  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State... Md County... Baltimore  
 City or town... Victory Villa  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 110 Yarmouth Drive  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war...

3. (a) FULL NAME  
Hulda P. Corey

3. (b) Social Security Number  
265-07-1805

4. Sex f 5. Color or race w 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife Herbert

6. (c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.) Jan 29, 1898

8. AGE: Years 30 Months 7 Days 7 If less than one day... hrs. ... min.

9. Birthplace Jewell Co. Md  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Archibald Davis

13. Birthplace Waynes Co. Ind

14. Maiden name Margaret Gately

15. Birthplace

16. Informant Poland Grey

Address 110 Yarmouth Drive, Victory Villa

17. Burial Date thereof 9/1/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematorium Oak Lawn

Location Guthrie Co. Md

18. Funeral director William Conner

Address 1217 St Paul St

19. Aug 31, 1948 A. W. Hedrick  
 (Date received by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 19 48 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21 19 48 to Aug 28 19 48 and that I last saw her alive on Aug 28 19 48

Immediate cause of death Pneumonia DURATION 2 days

Due to

Due to

Other conditions Cerebral hemorrhages multiple 3 yrs  
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jack Wexler, M.D. M. D. or other

Address 845 Jewelers Ave Date signed 8/29/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 830 42

## 1. PLACE OF DEATH:

County Baltimore  
 City or town 2802 Delaware Ave. Balto. Highlands  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore  
 City or town Baltimore Highlands  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2802 Delaware Ave.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war

## 3. (a) FULL NAME

JOHN EDGAR COCKERILL

## 3. (b) Social Security Number

?

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of ~~husband~~ wife Alice L. Cockerill  
 6. (c) If alive, give age years  
 7. Birth date of deceased (mo., day, yr.) Nov. 18, 1867  
 8. AGE: Years 80 Months 9 Days 2 It less than one day hrs. min.

9. Birthplace West Virginia  
 (Town, county, and state)  
 10. Usual occupation Carpenter- Retired  
 11. Industry or business  
 FATHER 12. Name John T. Cockerill  
 13. Birthplace Va.  
 MOTHER 14. Maiden name Unknown  
 15. Birthplace Unknown

16. Informant Mr. Edgar Cockerill  
 Address 2802 Delaware Ave. 27  
 17. Burial Burial Date thereof 8/24/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or place of interment Meadowridge Mem. Pk.  
 Location Baltimore Md.  
 18. Funeral director WM. J. TICKNER & SONS INC.  
 Address North & Pa. Aves. Balto. 17, Md.  
 19. 8/24 x8 BW Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 1948 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 1947 to August 20 1948  
 and that I last saw him alive on August 20 1948

Immediate cause of death Cerebral Hemorrhage DURATION 3 days  
 Due to  
 Due to  
 Other conditions Cerebral Atherosclerosis 2 years  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide  
 Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Paul H. Hedrick M. or other 8/20/48  
 Address Baltimore Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Balto.City or town College  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

433 Oriole Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town College  
(If outside city or town limits, write RURAL and give nearest town)Street No. 433 Oriole Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Anna Coleman

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

W

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

John P. Coleman

7. Birth date of deceased (mo., day, yr.)

Aug. 23, 1913

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

3411

hrs.

min.

9. Birthplace

Balto. Md.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

FATHER

12. Name

J.B. Zherber

13. Birthplace

Balto. Md.

14. Maiden name

Mar. Schwartz

15. Birthplace

Balto. Md.

16. Informant

John P. Coleman

Address

433 Oriole Ave.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Aug. 4 - 1948  
(month) (day) (year)

Cemetery or crematory

Eastern Cemetery

Location

Edmore Ave.

16. Funeral director

John G. Connolly

Address

418 Eastern Ave.

19.

(Date rec'd by registrar)

19. 48John G. Connolly  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 1st 1948, at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 22 1948, to Aug. 1 1948and that I last saw her alive on July 31 1948

Immediate cause of death

Anuria

DURATION

4 days

Due to

Kidney Block1 wk.

Due to

Carcinoma of ovary2

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Tumor left ovaryDate of op. Mar. 28, 1948

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Maxwell A. Mund

M. D. or other

Address

417 1/2 Eastern Ave.Date signed 8-3-48

THE UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

502.1. 20

RECEIVED  
AUG 10 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? since July 11, 1938

Hospital, institution, or street address where death occurred:

Spring Grove HospitalHow long in hospital or institution? since July 11, 1938

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard CountyCity or town Ellicott City  
(If outside city or town limits, write RURAL and give nearest town)Street No. Ellicott St  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Oswald G. Collier

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

M.

W.

single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 11, 18878. AGE: Years Months Days If less than one day  
61 0 14 hrs. min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Odd jobs

11. Industry or business

12. Name John M. Collier13. Birthplace Ohio14. Maiden name Annie Strawbridge15. Birthplace Maryland16. Informant Hospital recordsAddress Spring Grove State Hospital17. Burial Date thereof 8-27-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or mortuary St JohnsLocation Ellicott City Md18. Funeral director J.C. NeumannAddress Ellicott City Md19. 8/26 19 48 V.E. Harris  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 25, 1948 19 at 5:15 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11, 1938 19 to Aug. 25, 1948and that I last saw him alive on August 25, 1948 19

Immediate cause of death

Purpura Hemorrhagica

DURATION

3 daysDue to Hepatitis12 daysCardiac decompensation12 daysDue to Chronic valvular heart diseaseindefOther conditions Arteriosclerosisindef

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

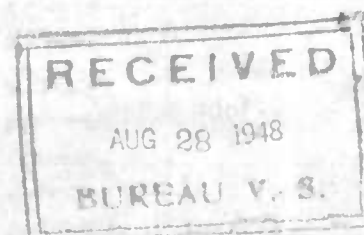
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Dr. Abraham M. Schneidmuhl  
Address Spring Grove Hosp Date signed 8/25/48



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

184

Registered No.

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address... 3051 Parktown

(c) Hospital or institution: Balt 14

(d) Length of stay in hospital or inst. (yrs., mos., or days).....

(e) Length of stay in Baltimore (yrs., mos., or days).....

## 3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

F

5. Color or race

W

6 (a) Single, married, widowed, or divorced.

married

6 (b) Name of husband or wife

Samuel S Coomer

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) May 10 1922

8. AGE: Years Months Days If less than one day

26

2

22

hr.

min.

9. Birthplace Coatsville Pa

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name Wm J Redmond

13. Birthplace York Co Pa

14. Maiden Name Blanch Flaherty

15. Birthplace Woodbine Pa

16 (a) Informant Samuel Allen Coomer

(b) Address 3051 Parktown Rd

17 (a) Burial (b) Date thereof Aug 3 48

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Airville

Location Airville York Co Pa

18 (a) Funeral director Martin A Kurtz

(b) Address Jarrettsville Md

19 (a) Aug 1948 (b) W. Carroll Van Horn

(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 3051 Parktown Rd (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

(f) Yes, name country

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Aug 1978, at 2 A M

21. I certify that I took charge of the remains described above, held an

Autopsy, Inspection or Inquiry thereon and from the evidence obtained

by said Autopsy, Inspection or Inquiry, find that said deceased came

to death on the day stated above, and death in my

opinion resulted from: natural causes ☐, accident ☐, suicide ☐,homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage

Due to Bullet Wounds of chest

and abdomen.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8/1/48 at ?

(b) Where did injury occur? 3054 Parktown Rd.

(c) Did injury occur at home, on farm, industrial place, in public

place? Home While at work?

(d) Means of injury

23. Signature Earl W. Roy M.D.

Date signed 1 Aug 78

Medical Examiner

Was death due to

Accident

Suicide

Homicide

Also state date &  
place of injury?



Item #22

Pending

Dr Razer

10/11/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Halethorp  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Authess Tourist Camp  
 How long in hospital or institution? 44.15 Washington Blvd

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(If born in this state, give residence of mother)  
 State Delaware County Bello  
 City or town Shipman's Landing  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4411 West Blvd  
 (If rural, give LOCATION)

(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed or divorced Married  
 6. (b) Name of husband or wife Grace Marshall  
 7. Birth date of deceased (mo., day, yr.) July 27, 1900 6. (c) If alive, give age 41 years  
 8. AGE: Years 48 Months — Days 9 If less than one day hrs. min.

9. Birthplace Shipman's Va.  
(Town, county, and state)10. Usual occupation Painter

11. Industry or business

12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Mrs. Grace CraigAddress White Plains N.C.17. Burial Date thereof Aug. 8, 1948  
(Burial, cremation, or reinterment. Which?) (month) (day) (year)Cemetery or crematory Friends Church Cem.Location White Plains N.C.18. Funeral director E. Astor's SonsAddress Edicott City, Md.19. Aug 6 19 48 J. Kuffer  
(Date rec'd by Registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5th, 1948 at 8-30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

DURATION

Acute cardiac failure

Due to

Due to Chronic alcoholism

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

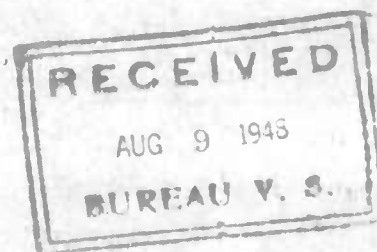
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Kuffer Supplied

M. D. or other

Address 1010 Leech Ave Date signed 8-5-48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:  
County Baltimore  
City or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 years  
Hospital, institution, or street address where death occurred:  
2557 Liberty Parkway  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State md County Baltimore  
City or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2557 Liberty Parkway  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME John E. Creswell 3. (b) Social Security Number

4. Sex m. 5. Color or race W. 6. (a) Single, married, widowed, or divorced m.

6. (b) Name of husband or wife Anna S. Creswell

7. Birth date of deceased (mo., day, yr.) June 25, 1896 6. (c) If alive, give age years

8. AGE: Years 72 Months 2 Days 5 If less than one day hrs. min.

9. Birthplace Harford County, Md.  
(Town, county, and state)

10. Usual occupation Chauffeur

11. Industry or business

12. Name Frank B. Creswell

13. Birthplace md

14. Maiden name Ida Creswell

15. Birthplace md

16. Informant Mrs. Anna S. Creswell

Address 2557 Liberty Parkway, Dundalk

17. Burial Date thereof Sept 2, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Union Chapel

Location Harford Co. Md.

19. Funeral director Roland S. Fisher

Address 2112 Dundalk Ave.

19. Sept 1 19 48 William M. Gree Jr  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 30, 1948 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 August 1948 to 30 August 1948 and that I last saw him alive on 28 August 1948

Immediate cause of death Cerebral Thrombosis DURATION 10 days

Due to Cerebral Arteriosclerosis unknown

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

2. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? SAVED

23. SIGNATURE Bernard W. Doud MD M. D. or other

Address 8 Liberty Parkway Date signed 31 Aug 48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08091

83b

RECEIVED

SEP 2 1948

BUREAU V. S.

Evidence for change of  
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FORM No. G 117 SEP 15 1948

CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:

County..... *Balto*

City or town..... *Essex*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Md.* County..... *Balto*

City or town..... *Essex*  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... *810 Essex Ave.*  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

*Antonina Czyzechowicz*

3. (b) Social Security Number

4. Sex..... *F* 5. Color or race..... *W* 6. (a) Single, married, widowed, or divorced..... *widowed*

6. (b) Name of husband or wife.....

7. Birth date of  
deceased (mo., day, yr.)

6. (c) If alive, give age..... years  
*11-31-1861*

8. AGE: Years..... *84* Months..... *86* Days..... If less than one day..... hrs. .... min.

9. Birthplace..... *Poland*  
(Town, county, and state)

10. Usual occupation..... *House wife*

11. Industry or business.....

12. Name..... *Frank Czyzechowicz*

13. Birthplace..... *Poland*

14. Maiden name..... *Unknown*

15. Birthplace.....

16. Informant..... *Maryanne Golabinski*

Address..... *810 Essex Ave.*

17. *Burial* Date thereof..... *9 2 48*  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... *Holy Rosary*

Location..... *Baltimore*

18. Funeral director..... *J. Burdysinski*

Address..... *1407 Eastern Ave.*

19. *8/31* 19. *48* *H. D. Hedrick*  
(Date reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *Aug 30* 19 *48* at *4 P.* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
*Aug 29* 19 *48* to *Aug 30* 19 *48*  
and that I last saw him/her alive on *Aug 30* 19 *48*

Immediate cause of death.....

*Cerebral apoplexy*

DURATION

*2 day*

Due to..... *Arterio-Sclerotic-Cardio-vascular disease*

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE..... *Geo. M. Baumgardner*

M. D. or other

Address..... *8552 Pheta Rd* Date signed..... *8-30-48*

MARGIN RESERVED FOR BINDING

VS A15

9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County Balto.City or town Arbutus Oaklee  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

203 Oaklee Village

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. CountyCity or town Balto.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 369 Evesham Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

MARVIN E. DAWSON

## 3. (b) Social Security Number

213-10-07664. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Janette W. Dawson7. Birth date of deceased (mo., day, yr.) March 27, 1893  
6. (c) If alive, give age years8. AGE: Years 55 Months 4 Days 24 It less than one day  
.....hrs. ....min.9. Birthplace Heathsville, Va.  
(Town, county, and state)10. Usual occupation Retired11. Industry or business Transit Co.12. Name Costetalo Dawson  
13. Birthplace Va.14. Maiden name Wilhelmina Sherman  
15. Birthplace Va.16. Informant Mrs. Janette W. DawsonAddress 369 Evesham Ave.17. Burial Date thereof 8/24/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Loudon Park Cem.Location Balto., Md.18. Funeral director WM. J. TICKNER & SONSAddress Balto., Md.19. 8/23/48 Dr. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21, 19 48 at 7:05 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....  
and that I last saw h.....alive on.....19.....

Immediate cause of death..... DURATION

Coronary occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Hedrick Keptilled  
M. D. or otherAddress 1010 Loudon Date signed 8-24-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The tombstone age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 33~

## 1. PLACE OF DEATH:

County BaltimoreCity or town Rural near Freeland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 37 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Rural near Freeland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1 1/2 mi. North  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Lloyd V. Day

## 3. (b) Social Security Number

180-09-4114

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Lyda Taylor6. (c) If alive, give age 35 years

7. Birth date of

deceased (mo., day, yr.) February 20, 1911

8. AGE:

Years

Months

Days

If less than one day

37513

hrs.

min.

9. Birthplace

Freeland, Md. R.D.  
(Town, county, and state)

10. Usual occupation

Punch Press Operator

11. Industry or business

Plastic Molding Plant

12. Name

Samuel P. Day

13. Birthplace

Maryland

14. Maiden name

Loma Viola Krout

15. Birthplace

Maryland

16. Informant

Mrs. Lyda Day

Address

Freeland, Md. R.D.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof August 6, 1948

Cemetery or crematory

Pine Grove W. Br.

Location

Parkton, Balto. Co., Md. R.D.

18. Funeral director

Joseph J. Hartenstein

Address

111 New Freedom, La.

19. Day

(Date rec'd by registrar)

1948Chute & Spitzer

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 3, 1948 at 12:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

Head on arrival  
Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. M. France

M. D. or other

Address

Parkton, Md.Date signed 8/4/48

RECEIVED

AUG 18 1948

BUREAU Y. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **35**

### 1. PLACE OF DEATH:

County **Baltimore**  
City or town **Rural near Parkton**  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **Maryland** County **Baltimore**  
City or town **Rural near Parkton**  
(If outside city or town limits, write RURAL and give nearest town)

Street No. **3 mi. N. of Parkton**  
(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (a) FULL NAME

**Charles Amos Dintelman, Jr.**

### 3. (b) Social Security Number

4. Sex **M** 5. Color or race **W** 6. (a) Single, married, widowed, or divorced **Single**

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **January 28, 1946**

8. AGE: Years **2** Months **6** Days **28** If less than one day hrs. min.

9. Birthplace **Baltimore, Md.**  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name **Charles A. Dintelman**

13. Birthplace **Elkton, Ill.**

MOTHER 14. Maiden name **Georgia Greene**

15. Birthplace **Sneedville, Tenn.**

16. Informant **Mrs. Charles A. Dintelman**

Address **Parkton, Md. R.D.**

17. Burial (Burial, cremation, or removal. Which?) **Burial** Date thereof **August 28, 1948**

Cemetery or crematory **Louden Park Cemetery**

Location **Baltimore, Md.**

18. Funeral director **Jacob Hartenstein**

Address **New Freedom, Pa.**

19. **Aug 27** 1948 **Elizabeth S. Scales** Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH **Aug 26** 1948 at **7:30 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death **Dead on arrival**

**Compound fracture of skull**

Duration

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide **Accident (Automobile)** Date of **Aug 26, 1948**

Where did injury occur? **Parkton, Balt. Md.** (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) **Highway**

Manner of injury **Auto Mobile Accident** Injured at work?

23. SIGNATURE **A. W. France** M. D. or Ch.

Address **Parkton, Md.** Date signed **8/26/48**

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Harmons Point  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Harmons Point  
(If outside city or town limits, write RURAL and give nearest town)Street No. 428 F St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Anna Christiana Doehreiner

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

George

7. Birth date of deceased (mo., day, yr.)

January 29, 18606. (c) If alive, give age D years

8. AGE:

Years

Months

Days

If less than one day

88

hrs.

min.

9. Birthplace

Germany  
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

None

FATHER

12. Name

Schmidt

13. Birthplace

Germany

MOTHER

14. Maiden name

Germany

15. Birthplace

Germany

16. Informant

Mrs. Rudolf Wild

Address

428 F St.

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

8/10/48  
(month) (day) (year)

Cemetery or crematory

Calclawn Cemetery

Location

Eastern Ave

18. Funeral director

John F. Henry Inc

Address

714 Light St.

19.

(Date received by Registrar)

Aug 9

19

48a. w. Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 7<sup>th</sup> 19 48, at 9<sup>25</sup> A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 July 19 48, to 7 Aug 19 48  
and that I last saw him alive on 1 July 19 48

Immediate cause of death

Heart disease

DURATION

with failure

Due to

Arteriosclerosisunknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Herbert Morrison

Address

2534 Parkway

M. D. or other

Date signed 7 Aug 48



Home of her daughter  
Mrs Rudolf Wild

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Sudbrook Park, Pikesville, Md  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

709 Clivedon Rd

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto  
 City or town Sudbrook Park, Pikesville, Md  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 709 Clivedon Road  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Bessie K. Doenges

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife

late William R.

7. Birth date of deceased (mo., day, yr.)

Oct 20

6. (c) If alive, give age years

1850

8. AGE:

Years

67

Months

9

Days

30

If less than one day

hrs.

min.

9. Birthplace

Balto Md

(Town, county, and state)

10. Usual occupation

=

11. Industry or business

FATHER

12. Name

Oden Bowie Knight

13. Birthplace

Maryland

MOTHER

14. Maiden name

Ella Duncan

15. Birthplace

Maryland

16. Informant

William Duncan Doenges

Address

709 Clivedon Rd Pikesville Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Aug 21/48

(month) (day) (year)

Cemetery or crematory

Lorraine Park

Location

Woodlawn Md

18. Funeral director

Harry H. Witzke

Address

4101 Edmondson Ave.

19. 8-20-48

(Date rec'd by registrar)

19 48

Dr P E Nichols

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 19

19

48 at 8:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 11

19

48 toAug 19

19

48

and that I last saw her alive on

8-19

-

Aug 19

19

48

Immediate cause of death

Coronary Thrombosis

DURATION

Sudden

Due to

Chronic Myocarditis?

Due

Stokes Adams Syndrome??

Other conditions

Arterial Hypertension??Arterio Sclerosis

(Include pregnancy within 3 months of death)

?

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. E. Nichols

M. D. or other

Address

Pikesville Md

Date signed

8/20/48

RECEIVED

AUG 22 1948

BUREAU V. S.

Address 1334 Sulphur Spring Date signed May 1988

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate exact age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Balto.  
 City or town Clark's Point Rd. Bowleys Quarters  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County .....  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1624 N. Broadway  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... ✓

## 3. (a) FULL NAME

ANNA (ANNIE) DORSCH

## 3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband George Dorsch  
 6.(c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) Dec. 1, 1868  
 8. AGE: Years 79 Months 8 Days 9 If less than one day ..... hrs. .... min.

9. Birthplace Germany  
 (Town, county, and state)  
 10. Usual occupation None  
 11. Industry or business

FATHER 12. Name Charles Arndt  
 13. Birthplace Germany  
 MOTHER 14. Maiden name Matilda Fulgrable  
 15. Birthplace Germany

16. Informant Mr. Oscar Dorsch  
 Address Clarks Point Rd.

17. Burial Date thereof 8/12/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery St. Matthews  
 Location Baltimore, Md.

18. Funeral director WM. J. TICKNER & SONS INC.  
 Address North & Pa. Aves. 17.

19. A/11 19 48 A.W. Hedrich  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9, 19 48 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 45 19 45 to Aug 9 19 48  
 and that I last saw h. is alive on August 9 19 48

Immediate cause of death Cerebral thrombosis DURATION 1 hr.

Due to arteriosclerotic cardio-vascular renal disease 34y

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Juleson & S. M. D. or other

Address 6217 Harford Rd Date signed 8/10/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

## 1. PLACE OF DEATH:

County BaltimoreCity or town Owings Mills  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 24 yrs

Hospital, institution, or street address where death occurred:

Reewood State Training SchoolHow long in hospital or institution? 24 yrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 701 Easley

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Adam Gust (Droz)

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 2, 19088. AGE: Years Months Days If less than one day  
39 9 20 hrs. min.9. Birthplace Baltimore Maryland  
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Valentine Drost13. Birthplace Poland14. Maiden name Marion Rechen15. Birthplace Poland16. Informant Hospital RecordsAddress Reewood State Tr. School17. Burial Burial Date thereof 8-25-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Holy RosaryLocation Seymour Side Rd.18. Funeral director Silber & Feiler Inc.Address 403 S. M. St. N. 3119. 8/28 19. 48 8-10 Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 19. 48 at 2:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 19 19. 48 to August 22 19. 48and that I last saw him alive on August 22 19. 48Immediate cause of death Acute Corneal DetachmentDue to Chronic EndocarditisChronic Myocarditis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Vera B. Johns M.D.Address Reewood State Tr. Sch. Date signed 8/23/48



NAME OF MOTHER: BIBLE  
RECORD FILMED G117  
August 26, 1948 L.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 18 days  
Hospital, institution, or street address where death occurred:  
Veterans Administration Hospital  
How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4605 Minnesota Avenue  
(If rural, give LOCATION)  
2.(a) If veteran, name war WW ✓

3. (a) FULL NAME

LURENA R. W. DUMBELL

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife \_\_\_\_\_  
9.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) December 29, 1864  
8. AGE: Years 83 Months 7 Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Md.  
(Town, county, and state)  
10. Usual occupation Unemployed  
11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Moses Richardson  
13. Birthplace Albany, N. Y.  
14. Maiden name Jane ~~Carne~~ Caine  
15. Birthplace Albany, N. Y.

16. Informant Clinical Records, Vet. Adm. Hosp.  
Address Fort Howard, Md.

17. Burial Date thereof 8/16/48  
(Burial, cremation, or removal, which?) Month (day) (year)

Cemetery or crematory Forest Park  
Location Baltimore, Md.

19. Funeral director Thurman Corp  
Address 1217 1/2 Paul St

19. 8/14 28 H. W. Hedrick  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1948, at 8:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
July 26 1948, to August 13 1948  
and that I last saw h.er alive on August 13 1948

Immediate cause of death CARDIAC DILATATION AND HYPERTROPHY  
WITH PULMONARY EDEMA DURATION Unknown

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE HRC \_\_\_\_\_

H. C. MANAUGH, M.D., CHIEF PROFESSIONAL SER

Address VAH, Ft. Howard, Md. Date signed 8/13/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH: *Baltimore*  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....*MD* County.....*BALTA*  
 City or town.....*Franklinville*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
*Ada Belle Eisner*  
 4. Sex.....*F* 5. Color or race.....*W* 6. (a) Single, married, widowed, or divorced.....*married*  
 6.(b) Name of husband or wife.....*Edw H Eisner*  
 B.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, year).....*July 22 - 1929*  
 8. AGE: Years.....*24* Months..... Days.....*29* If less than one day..... hrs. .... min.

9. Birthplace.....*BALTA - CO MD*  
 (Town, county and state)  
 10. Usual occupation.....*Homemaker*  
 11. Industry or business.....*Homemaker*  
 12. Name.....*Harry E. Drummer*  
 13. Birthplace.....*Harford MD*  
 14. Maiden name.....*York Burtis*  
 15. Birthplace.....*BALTA CO MD*  
 16. Informant.....*Edw H Eisner*  
 Address.....*Franklinville*

17. *Rural* Date thereof.....*Aug-24-48*  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory.....*Belair Burial Park*  
 Location.....*Lassahn Funeral Home*  
 18. Funeral Director.....*7401 Belair Rd*  
 Address.....*8/22/48*  
 19. (Date rec'd by registrar) 19.....*1948* Registrar.....

3. (b) Social Security Number

*217-22-5883*

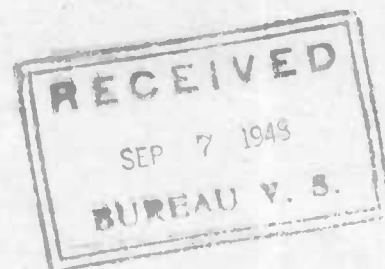
## MEDICAL CERTIFICATION

20. DATE OF DEATH.....*August 21* 19.....*48* at.....*11:15* M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....*Dec 21* 19.....*47* to.....*August 21* 19.....*48*  
 and that I last saw him alive on.....*August 21* 19.....*48*  
 Immediate cause of death.....*Carcinoma of uterus, year*  
 DURATION.....  
 Due to.....  
 Due to.....  
 Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town)..... (County)..... (State).....  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?.....  
 23. SIGNATURE.....*John H. Drummer*  
 Address.....*BALTA* Date signed.....*8/24/48*



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

### 1. PLACE OF DEATH:

County Baltimore  
City or town Woodlawn 7 Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 1/2 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

Anna M Evans

### 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Samuel F Evans

7. Birth date of deceased (mo., day, yr.) May 2 - 1868 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 80 Months 3 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Miltonsburg Ohio  
(Town, county, and state)

10. Usual occupation Home duties

11. Industry or business

12. Name Nicholas Beiber

13. Birthplace Alsace Lorraine France

14. Maiden name Luina Feltner

15. Birthplace Bavaria

16. Informant Walter V Evans

Address 5520 Wayne Ave Baltimore

17. Burial Date thereof 9/2/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Woodlawn

Location Woodlawn Md

18. Funeral director Mr J. Fisher & Son

Address North & Penna - Bk

19. 9/30/48 9/11/48  
(Date rec'd by registrar) (Date rec'd by registrar)

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Woodlawn 7 Md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2615 Woodlawn Ave  
(If rural, give LOCATION)

2. (a) If veteran, name war

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 19 48 at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-22- 19 48 to 8-30 19 48

and that I last saw him alive on 8-29-48 19 \_\_\_\_\_

Immediate cause of death Chronic Myocarditis DURATION 1

Due to Arteriosclerotic ?

Due to Arteriosclerosis ?

Other conditions Senility ?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE E E Michael MD M. D. or

Address Pikesville Md Date signed 9/30/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08104

Reg. Dist. No. 31

## 1. PLACE OF DEATH:

County BaltimoreCity or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltimoreCity or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)Street No. Johnny cake Rd  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Nathan

7. Birth date of deceased (mo., day, yr.)

18866.(c) If alive, give age 62 years

8. AGE:

Years 62Months -Days -

If less than one day

hrs. - min. -

8. Birthplace

Russia  
(Town, county, and state)

10. Usual occupation

Home duties

11. Industry or business

Samuel ?

12. Name

Russia

13. Birthplace

Ukraine

14. Maiden name

Russia

15. Birthplace

Nathan Finkelstein

18. Informant

Woodlawn Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 8-9-48

(month) (day) (year)

Cemetery or crematory

Washington DC

Location

Jack Lewis Inc

18. Funeral director

Address 2100 Eutaw Place19. Aug 2 19 48 Q. W. Hedrick Registrar

(Date received by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 1st 19 48 at 9:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 - to 19 -and that I last saw him alive on 19 -

Immediate cause of death

Acute cardiac failure

Due to

Cardiovascular disease

Due to

Diabetes Mellitus

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Dr. M. KiefferAddress 1010 RedmanDate signed 8-1-48

PLEASE WRITE PLAINLY, IN UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mount Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 yrs., 9 mos., 17 days  
 Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. T. B. Sanatorium  
 How long in hospital or institution? 3 yrs., 9 mos., 17 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Howard Co.  
 City or town Ellicott City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R.F.D. #40, Frederick Pike  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war. ✓

## 3. (a) FULL NAME

Mr. James R. Fredericks

## 3. (b) Social Security Number

219-18-4112

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife  
 7. Birth date of deceased (mo., day, yr.) July 30, 1922 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 26 Months 0 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
 (City, county, and state)  
 10. Usual occupation Paper Barrier  
 11. Industry or business  
 12. Name James M. Fredericks  
 13. Birthplace Howard Co., Md.  
 14. Maiden name Ida C. Ubel  
 15. Birthplace Balto. Co., Md.

16. Informant James Fredericks  
 Address Fred. Pike, Ellicott City, Md.  
 17. Burial Date thereof Aug. 11, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Taylor Family Cemetery  
 Location Ellicott City, Howard Co., Md.  
 18. Funeral director Easton & Sons  
 Address Ellicott City, Md.

19. Aug. 8, 1948 Helen R. Mayer  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1948, 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 22, 1944 to Aug. 8, 1948 and that I last saw him alive on Aug. 8, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION 4 yrs.

Due to Tubercle Bacilli

Other conditions Draining tuberculous sinus of left jaw. 3 yrs.  
 (Include pregnancy within 8 months of death)

Major findings of operations No operation  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE B. J. Siegel M.D. M. D. or other \_\_\_\_\_  
 Address Mt. Wilson, Md. Date signed 8/8/48



**RECEIVED**

AUG 11 1948

**BUREAU V. S.**

08106

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

## 1. PLACE OF DEATH:

County Balt  
City or town Randallstown P.D.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

4 Months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltCity or town Randallstown P.D.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

LOTTIE K. FREEMY

## 3. (b) Social Security Number

4. Sex F 5. Color or race White 6.(a) Single, married, widowed, or divorced W6.(b) Name of husband or wife Benjamin L. Freemy7. Birth date of deceased (mo., day, yr.) 2/14th 1890 6.(c) If alive, give age \_\_\_\_\_ years8. AGE: Years 58 Months 6 Days 26 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Baltimore  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business at home12. Name Nelson Hawkins13. Birthplace NY14. Maiden name Barton15. Birthplace MD16. Informant Nelson H. FreemyAddress Graves Hill Village F.F. Vas17. Burial Date thereof Aug 30-1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Green Mount CemLocation City18. Funeral director Leelrich Funeral HomeAddress 2008 Orleans St19. 8/27 19 48 AW Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 26 August 1948 at 12:45 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on  
22 August 1948 to 19and that I last saw him alive on 22 August 1948Immediate cause of death cardiorespiratory failure DURATION 1 dayDue to Carcinoma of right breast with metastases unknownDue to \_\_\_\_\_  
Other conditions Pathological fracture rt hip  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Paul X Rouse MD M. D. or otherAddress Pikeville 8 Md Date signed 26 Aug 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0661  
—  
25  
1961

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *42*

### 1. PLACE OF DEATH:

County *Baltimore*

City or town *Haitheory*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? *40 years in inst.*

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Balt*

City or town *(If outside city or town limits, write RURAL and give nearest town)*

Street No. *4400 Washington Blvd*  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

*Katie Kazmiera Fruhling (Freling)*

### 3. (b) Social Security Number

4. Sex *F.* 5. Color or race *W.* 6. (a) Single, married, widowed, or divorced *Married*

6. (b) Name of husband or wife *Ferdinand Otto Fruhling*

7. Birth date of deceased (mo., day, yr.) *Aug 18 - 1886* 6. (c) If alive, give age *48* years

8. AGE: Years *61* Months *11 mos* Days *25* If less than one day *hrs. min.*

9. Birthplace *Poland*  
(Town, county, and state)

10. Usual occupation *Housewife*

11. Industry or business *Mikolaj Kurowski*

12. Name *Mikolaj Kurowski*

13. Birthplace *Poland Mierzejewski*

14. Maiden name *Frances Mierzejewski*

15. Birthplace *Poland*

16. Informant *Husband*

Address *4400 Washington Blvd. Balto. County*

17. Burial Date thereof *Aug 17 1948*  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory *Holy Rosary Cem*

Location *Baltimore County*

18. Funeral director *John M. Weber*

Address *401 S. Chester Street*

19. *Aug 48* (Date rec'd by registrar) Registrar *[Signature]*

### MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 13 1948* at *7:30 P*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Aug 12* 19*48* to *Aug 13* 19*48* and that I last saw him alive on *Aug 13* 19*48*

Immediate cause of death *Carcinoma of uterus* DURATION *5 yr.*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations *Carcinoma* Date of op. *1943*

Autopsy results *PHYSICIAN: Please underline the cause to which death should be charged statistically.*

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Willards Farrow M. D.*

Address *1711 Selma St.* Date signed *Aug 14-48*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 88

08108

1. PLACE OF DEATH:

County Baltimore  
City or town Towson 4, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 70 days  
Hospital, institution, or street address where death occurred:  
Eudowood Sanatorium, Towson 4, Md.  
How long in hospital or institution? 70 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Baltimore Md.  
City or town Baltimore (28)  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 49 Delray Ave  
(If rural, give LOCATION)  
2. (a) If veteran, name war Spanish American

3. (a) FULL NAME

William B. Gardner

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Grace M Gardner

7. Birth date of deceased (mo., day, yr.) March 14, 1874 1876 6. (c) If alive, give age 72 years

8. AGE: Years 72 Months 5 Days 17 If less than one day hrs. min.

9. Birthplace Prince George Co. Md.  
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name Richard F. Gardner

13. Birthplace Anne Arundel Co. Md.

14. Maiden name Mollie A. Freeman

15. Birthplace Anne Arundel Co. Md.

16. Informant Personal history - hospital records

Address Eudowood Sanatorium, Towson 4, Md.

17. Burial Date thereof Sept 3, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Balto National

Location Baltimore City

18. Funeral director Edwards & MacNabb

Address Catonville Md.

19. Sept 2 19 48 G. W. Hyndrick  
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 1948 at 10:50 p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 19 48 to Aug 31 19 48

and that I last saw him alive on Aug 31 19 48

Immediate cause of death Pulmonary Tuberculosis DURATION April 1947

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE N. A. Bridges M. D. or other

Address Towson 4, Maryland Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:  
County Balto.  
City or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
7010 Belclare Rd.  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Md. County Balto.  
City or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 7010 Belclare Rd.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME Russell Gernand 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife CARRIE ALICE GRABILL  
7. Birth date of deceased (mo., day, yr.) Mar 25/1901

8. AGE: Years 47 Months 4 Days 26 (It less than one day) hrs. min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Welding Foreman

11. Industry or business Bethlehem Steel Co.

12. Name Charles E. Gernand

13. Birthplace Maryland

14. Maiden name Fannie E. Morningstar

15. Birthplace Maryland

16. Informant Carrie G. Gernand

Address 7010 Belclare Rd. Dundalk

17. Burial Date thereof Aug 23 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mountain View Cemetery

Location Union Bridge, Md.

18. Funeral director Roland L. Fisher

Address 2112 Dundalk Ave

19. Aug 22 19 48 Dundalk Md.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1948 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 to 19

and that I last saw him alive on 19

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. J. J. Gernand M. D. or other

Address Balto Co. Dundalk Date signed 8/22/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**RECEIVED**

AUG 23 1948

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 08110 44

## 1. PLACE OF DEATH:

County BaltoCity or town Colgate  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltoCity or town Colgate  
(If outside city or town limits, write RURAL and give nearest town)Street No. 7520 Carroll Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

4. Sex m5. Color or race W6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Katherine Goldsborough

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age years

8. AGE: Years 62 Months Days If less than one day  
hrs. min.8. Birthplace Baltimore  
(Town, county, and state)10. Usual occupation General Painter

11. Industry or business

12. Name Joe Goldsborough13. Birthplace Md14. Maiden name Emma Brooks15. Birthplace Md16. Informant Walter GoldsboroughAddress 112 S Maderia St17. Burial Date thereof Sept-1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak LawnLocation City18. Funeral director Widrich Funeral HomeAddress 2008 Orleans St19. 9-8-48 19 48 Widrich  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 19 48 at 6:02 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

April 19 48 to Aug. 30 19 48and that I last saw him alive on Aug. 29 19 48Immediate cause of death Cardiac failure DURATION 12 hrsDue to Arteriosclerosis & infarction 4 moDue to Hypertensive Cardiovascular disease unknown

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph B. ... M. D. or otherAddress 422 Western Ave Date signed 8/30/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1986  
27  
1948

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

## 1. PLACE OF DEATH:

County Balto.City or town Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 624 Main St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Blanche Shurlock Gray

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed6. (b) Name of husband or wife David W. Gray

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 18608. AGE: Years Months Day If less than one day  
87 10 19 hrs. min.9. Birthplace Darlington Pa.  
(Town, county, and state)10. Usual occupation Housework

## 11. Industry or business

12. Name Dr. Wm. C. Shurlock13. Birthplace Penna.14. Maiden name Rebecca Dilsworth15. Birthplace Penna16. Informant Miss Nellie M. GrayAddress Reisterstown, Md.17. Burial Date thereof Aug. 31, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Druid RidgeLocation Balto. Co.18. Funeral director J. F. Eline - SonsAddress Reisterstown, Md.19. 8-30-48 Mary B. Eline  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1948 at 3 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
2-3-48 1948 to Aug 29 1948.and that I last saw him alive on Aug 28 1948.Immediate cause of death Carcinoma of Stomach DURATION 3 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. D. Caples, M.D. M. D. or otherAddress Reisterstown, Md. Date signed 8-30-48

RECEIVED

SEP 2 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

### 1. PLACE OF DEATH

County Baltimore

City or town Fullerton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Fullerton  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Forge Road  
(If rural, give LOCATION)

2.(a) If veteran, name war No

### 3. (a) FULL NAME

Moses Lewis Gwynn

### 3. (b) Social Security Number

212-24-9711

#### 4. Sex

Male

#### 5. Color or race

Colored

#### 6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Harriett Louisa Nelson

7. Birth date of deceased (mo., day, yr.) June 12, 1879

6. (c) If alive, give age 68 years

8. AGE: Years 69 Months 6 Days 6 If less than one day hrs. min.

9. Birthplace Glenn Arm, Md. Balto. Co.  
(Town, county, and state)

10. Usual occupation Janitor

11. Industry or business State Teachers College

12. Name Josiah Gwynn

13. Birthplace Glenn Arm, Md.

14. Maiden name Margaret Ontario Jane Roberts

15. Birthplace Canada, Ontario

16. Informant Jos. Gwynn, son

Address Forge Rd. Fullerton Md.

17. Burial Date then Sept. 1-1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mt. Zion

Location Longgreen, Balto. Co. Md

18. Funeral director Bro. James R. Hensley

Address 578 W 3rd St

19. Aug 3, 1948 B. W. Hedrick  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1948 at 6:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to... 19...

and that I last saw h None 19...

Immediate cause of death Heart disease, chronic myocarditis

decompensated

#### DURATION

6 yrs.

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

.....Date of op. ....

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Rollin C. Hudson MD, DME.

M. D. of other

Address Towson Md Date signed 8/29/48.

MARGIN RESERVED FOR BINDING

9-45-15M

NS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



08115

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 44

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 98 Days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Md.  
 How long in hospital or institution? 98 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 620 S. Luzerne Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WW-2

## 3. (a) FULL NAME

HENRY HAAS

## 3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of deceased or wife Single 6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 10-1-06  
 8. AGE: Years 41 Months 10 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

12. Name Joseph Haas

13. Birthplace Baltimore, Md.

14. Maiden name Julie Wrigely

15. Birthplace Baltimore, Md.

16. Informant Clinical Records, Vets. Adm. Hosp.  
Fort Howard, Md.  
 Address

17. Burial Date thereof 8 16 48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sacred Hearts Cemetery  
Baltimore, Md.

Location

18. Funeral director Lilly & Zeiler  
Baltimore, Md.  
 Address

19. 8/13 19 48 Ad Medical  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 12, 19 48 at 3:13 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6, 19 48, to August 12, 19 48  
 and that I last saw him alive on August 12, 19 48

Immediate cause of death CARDIAC HYPERTROPHY  
AND DILATATION WITH EMPHYSEMA

DURATION  
Unknown

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated Above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE Jr. Saunders M. D. or other

Address VAH Fort Howard, Md. Date signed 8-12-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

08114

44

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 Days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Md.  
 How long in hospital or institution? 8 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balt  
 City or town Randallstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Liberty Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war SAV

## 3. (a) FULL NAME

LEROY V. HALLER

## 3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of ~~husband~~ wife Ella Haller  
 7. Birth date of deceased (mo., day, yr.) 7-24-76 6.(c) If alive, give age 56 years  
 8. AGE: Years 72 Months 0 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Philadelphia, Pa.  
 (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

12. Name Franklin Haller  
 13. Birthplace Pennsylvania

14. Maiden name Gertrude Vanderslice  
 15. Birthplace Phoenixville, Pa.

16. Informant Clinical Records, Vets. Adm. Hosp.  
 Address Fort Howard, Maryland

17. Burial Date thereof 8/16/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Baltimore National Cemetery  
 Location Baltimore, Md.

18. Funeral director Howard N. Blight Jr.  
 Address 6009 Hayford Road

19. 5/14 19 48 Dr. W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 11, 19 48 at 11:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 3, 19 48 to August 11, 19 48  
 and that I last saw him alive on August 11, 19 48

Immediate cause of death CARCINOMA OF THE SIGMOID COLON DURATION Unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated Above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE For Samuel M. D. or other

Address VAH Fort Howard, Md. Date signed 8-12-48



RECEIVED

AUG 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mount Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 0 yrs., 2 mos., 11 days  
 Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. T. B. Sanatorium  
 How long in hospital or institution? 0 yrs., 2 mos., 11 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3811 Yolanda Road  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

James E. Harding

## 3. (b) Social Security Number

218-03-1918

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Birdie Harding  
 7. Birth date of deceased (mo., day, yr.) September 20, 1895 6. (c) If alive, give age 32 years  
 8. AGE: Years 52 Months 10 Days 19 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)

10. Usual occupation Steam Fitter

11. Industry or business \_\_\_\_\_

FATHER 12. Name James E. Harding  
 13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden name Mary McCarthy  
 15. Birthplace Ireland

16. Informant James E. Harding  
 Address 3811 Yolanda Rd., Balto., Md.

17. Burial Burial Date thereof 8/12/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Parkwood Cemetery

Location 3310 Taylor Ave., Balto., Md.

18. Funeral director Leonard J. Ruck

Address 5305 Harford Rd., Balto., Md.

19. Aug. 8, 1948 Walter R. Mayer  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1948 10:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28, 1948 to August 8, 1948 and that I last saw him alive on August 8, 1948.

Immediate cause of death Pulmonary Tuberculosis DURATION 3 yrs.

Due to Tubercle Bacilli

Due to \_\_\_\_\_

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations No operation.

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE B. I. Siegel M.D. M. D. or other \_\_\_\_\_

Address Mt. Wilson, Md. Date signed 8/8/48

RECEIVED  
AUG 11 1948  
BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 177 Days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Fort Howard, Maryland  
 How long in hospital or institution? 177 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County   
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 754 Waesche Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WW-2

## 3. (a) FULL NAME

EDDIE R. HARDY

## 3. (b) Social Security Number

212-111-7767

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single

8.(b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.) 6-3-18 8.(c) If alive, give age  years

8. AGE: Years 30 Months 2 Days 24 If less than one day  hrs.  min.

9. Birthplace Greenville, N. C.  
(Town, county, and state)10. Usual occupation Laborer11. Industry or business 12. Name Thomas Hardy13. Birthplace North Carolina14. Maiden name Trumilla Darden15. Birthplace North Carolina

16. Informant Clinical Records, Vets. Adm. Hosp.  
 Address Fort Howard, Maryland

17. Removal Aug 30, 1948  
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Greenville, N.C.Location Greenville, N.C.18. Funeral director Charles R. LawAddress 802 Madison Ave

19. August 28 19 48 William M. Kelly Jr.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 19 48, at 2:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3, 19 48, to August 27, 19 48, and that I last saw him in alive on August 27, 19 48.

Immediate cause of death Pulmonary Tuberculosis far advanced bilateral, active. DURATION 2-1/2  
Yrs.

Due to Due to Other conditions 

(Include pregnancy within 8 months of death)

Major findings of operations Date of op. Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of 

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury  Injured at work? 23. SIGNATURE Robert D. Dooley, M.D. M. D. or other

Address VAH, FT. HOWARD, MD. Date signed 8-27-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 28 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08118

Reg. Dist. No. 37

### 1. PLACE OF DEATH:

County Baltimore  
City or town R.F.D. 8 Towson  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 Months  
Hospital, institution, or street address where death occurred:  
Pots Spring Road  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
City or town Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Pots Spring Road  
(If rural, give LOCATION)  
2(a) If veteran, name war

### 3. (a) FULL NAME

Louise Newton Harrall

### 3. (b) Social Security Number

4. Sex F. 5. Color or race W 6. (a) Single, married, widowed, or divorced Widow  
6. (b) Name of husband or wife Edwin T. Harrall  
6. (c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) September 21st, 1872  
8. AGE: Years 75 Months 10 Days 28 If less than one day hrs. min.

9. Birthplace Providence R.I.  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business Home  
FATHER 12. Name Henry W. Newton  
13. Birthplace Yorkshire - England  
MOTHER 14. Maiden name Louise Hunter  
15. Birthplace Providence R.I.

16. Informant Edwin R. Harrall  
Address R.F.D. 8-Towson 4 Md

17. Removal Date thereof Aug 22nd 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Brookside  
Location Englewood N.J.

18. Funeral director John Burns' Sons  
Address 610 York Road Towson 4

19. 8-20 45 Wilmer Benson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 19th- 19 48 at 10.18 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 19 19 48 to Aug. 19 19 48  
and that I last saw h. ER alive on August 8, 19 19 48

Immediate cause of death Arterio-sclerotic Heart Disease DURATION 12 mo.  
Due to Coronary Artery Disease 12 mo.  
Due to Hypertension 2 years  
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Crawford N. Kilpatrick Jr. M. D. or other  
Address 6 E. Edger St. Date signed 8-20-48

MARGIN RESERVED FOR BINDING

VS. A15 9-45-15M

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

RECEIVED  
SEP 17 1948  
BUREAU A. S.

Mr. William F. Evans  
Rockyville  
WA

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 253 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, Md.How long in hospital or institution? 253 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CalvertCity or town Chase  
(If outside city or town limits, write RURAL and give nearest town)Street No. West Twin River Beach  
(If rural, give LOCATION)2. (a) If veteran, name war WW I

## 3. (a) FULL NAME

RAYMOND K. HAYES

## 3. (b) Social Security Number

Unknown

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	--

8. (b) Name of husband or wife Helen Hayes8. (c) If alive, give age 60 years7. Birth date of deceased (mo., day, yr.) 5-18-87

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>2</u>	<u>28</u>	.....hrs. ....min.

9. Birthplace Norristown, Pa.  
(Town, county, and state)10. Usual occupation Janitor

11. Industry or business

12. Name Michael Hayes13. Birthplace Pennsylvania14. Maiden name Mary Grady15. Birthplace Pennsylvania16. Informant Clinical Records, Vets. Adm. Hospital  
Address Fort Howard, Maryland17. Burial  
(Burial, cremation, or removal. Which?) Date thereof Aug. 20, 1948  
(month) (day) (year)  
Cemetery or crematory Baltimore National Cemetery  
Baltimore, Md.  
Location18. Funeral director William Cook, Inc.  
Address 1217 St. Paul St., Baltimore, Md.19. 8-18-48  
(Date rec'd by registrar) Registrar [Signature]

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1948, at 5:50 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
December 8, 1947, to August 17, 1948  
and that I last saw him alive on August 17, 1948Immediate cause of death PULMONARY  
TUBERCULOSIS, BILATERAL

DURATION

1 year

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 8 months of death)

Major findings of operations .....

.....Date of op. ....

Autopsy results Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. or otherAddress VAH Fort Howard, Md. Date signed 8-17-48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County..... Baltimore

City or town..... Towson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Sheppard &amp; Enoch Pratt Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Cecil

City or town..... New Windsor  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (a) FULL NAME

MRS. EMMA HIBBERD (MRS. CHARLES J.)

## 3. (b) Social Security Number

## 4. Sex

F

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

W

## 6. (b) Name of husband or wife

CHARLES J. HIBBERD

## 7. Birth date of

(deceased (mo., day, yr.))

April 30, 1858  
NOT KNOWN

6. (c) If alive, give age..... years

## 8. AGE:

90

Years

Months

3

Days

3

If less than one day

hrs.

min.

## 9. Birthplace

MARYLAND  
(Town, county, and state)

## 10. Usual occupation

HOUSEWIFE

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

GRANVILLE HAINES

## 13. Birthplace

MARYLAND

## 14. Maiden name

SUSAN SHEPPARD

## 15. Birthplace

MARYLAND

## 16. Informant

Hospital records

## Address

## 17.

Burial  
(Burial, cremation, or removal, Which?)

Date thereof

Aug. 4 - 48  
(month) (day) (year)

## Cemetery or crematory

Friends Cemetery

## Location

Union Bridge, Md.

## 18. Funeral director

H. H. Heston, T. A. Heston

## Address

Union Bridge, New Windsor, Md.

## 19.

Aug 3  
(Date rec'd by registrar)

19 48

Granville Haines

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 2 AUGUST 19 48, at 7:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

28 JULY

19 48, to 2 AUG.

19 48

and that I last saw her..... alive on 2 AUG 19 48

Immediate cause of death..... RESPIRATORY  
FAILURE

DURATION

6 DAYS

Due to LOBAR PNEUMONIA

Due to CHRONIC MYOCARDITIS  
AND MYOCARDIAL DEGENERATION

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Harry M. Mordock  
M. D. or other

Address Sheppard-Pratt, Towson, Md.

Date signed

MARGIN RESERVED FOR BINDING

VS A15

9-45-5M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8831

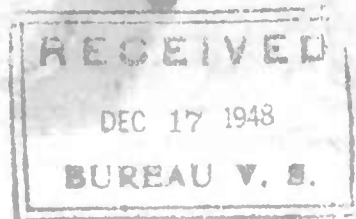
108

50 32



RECEIVED  
AUG 5 1948  
SOUTHERN COUNTY  
SHERIFFS DEPARTMENT

DEC 17 1948



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: Baltimore County  
 County Novel Convalescent Home  
 City or town 5313 Edmondson Ave.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State Md County  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 628 Aldershot Rd.  
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Mary Elizabeth Hofmann

3. (b) Social Security Number

4. Sex Female 5. Color of race W 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Charles  
 7. Birth date of deceased (mo., day, yr.) 1891 8. (c) If alive, give age years

8. AGE: Years 77 Months Days If less than one day hrs. min.

9. Birthplace Unknown  
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name Md

13. Birthplace Md

14. Maiden name

15. Birthplace Md

16. Informant Mrs E. R. Wade

Address 628 Aldershot Rd

17. Burial Date thereof Sept 1-48  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory London Park

Location Frederick Rd

18. Funeral director Joseph Kasinski Inc.

Address 602 Washington Bldg

19. 8-31-48 W. E. Harry  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29-48 19 330 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-1-47 19 8-29 19 48

and that I last saw him alive on 8-29-48 19

Immediate cause of death Chs. Myocarditis

Due to Cerebral Arterio

Due to Sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reece Howell M. D. or other

Address Catonsville Date signed 8-31

1871  
66  
8461

RECEIVED

SEP 2 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 40

## 1. PLACE OF DEATH:

County Walter AveCity or town Fullerton Balto Co. Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto 40City or town Fullerton  
(If outside city or town limits, write RURAL and give nearest town)Street No. Walter Ave Fullerton Md.  
(If rural, give LOCATION)

2.(a) If veteran, name war:

## 3. (a) FULL NAME

Kate Hofstetter

## 3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) June 8, 18698. AGE: Years 79 Months 1 Days 24 If less than one day hrs. min.9. Birthplace Balto. Co. Md.  
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

12. Name George Hofstetter13. Birthplace Balto Co. Md.14. Maiden name Mary E. Hunter15. Birthplace Balto. City Md.16. Informant Mr. August HofstetterAddress Walter Ave Fullerton P.O.17. Burial Date thereof 8 4 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Landon Park CemeteryLocation Balto City Md.18. Funeral director Lassahn Funeral HomeAddress 7401 Belair Rd19. 8/2/48 Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 1948 at 10<sup>30</sup> A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. None 18.Immediate cause of death Heart disease, chronic myocarditis DURATION 3 yrs +Due to Senile changes with arteriosclerosis 3 yrs +

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide Date of

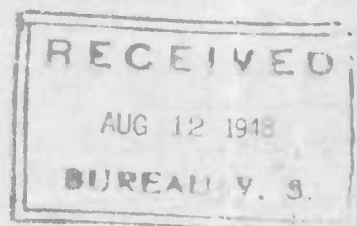
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Rollin C. Hudson MD. DME. M. D. or otherAddress Towson Md. Date signed 8/2/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



08152

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 39

1. PLACE OF DEATH:

County Balto  
City or town Monkton - Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Lifetime  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State md County Balto  
City or town Monkton - Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2. (a) If veteran, name war

3. (a) FULL NAME

Annie Brown Holmes

3. (b) Social Security Number

4. Sex F. 5. Color or race W 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Charles Clinton Holmes

7. Birth date of deceased (mo., day, yr.) Mar. 19, 1872 6. (c) If alive, give age - years

8. AGE: Years 76 Months 8 Days 10 If less than one day - hrs. - min.

9. Birthplace A. A. Co. md.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Basil Brown

13. Birthplace A. A. Co. md.

MOTHER 14. Maiden name Ed. Clara Bond

15. Birthplace A. A. Co. md.

16. Informant John Bacon Holmes

Address Monkton md

17. Burial Date thereof Aug 31 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St James

Location Monkton, md.

18. Funeral director Landrum M. Brooks

Address Sparks, md.

19. 8/31 1948 Anna Price  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29 1948 at 3 a m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 22 1948 to Aug 29 1948

and that I last saw him alive on Aug 28 1948

Immediate cause of death Cerebral hemorrhage DURATION 1 week

Due to

Due to

Other conditions Hypertension

Arterio-sclerous  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. W. France M. D. 8/29/48

Address Parkton, md. Date signed

MARGIN RESERVED FOR BINDING

I

9.45:15M

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 2 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 44

## 1. PLACE OF DEATH:

County Balto  
 City or town 2538 Sycamore Ave  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Edgemere  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2538 Sycamore Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Herman Holmes

## 3. (b) Social Security Number

4. Sex M 5. Color or race C 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 8-2-48 6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day  
 hrs min.

9. Birthplace Edgemere Md Balto  
 (Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER  
 12. Name Juanita Youngblood  
 13. Birthplace Edgemere Md  
 14. Maiden name Brian Holmes  
 15. Birthplace Edgemere Md

16. Informant Juanita Holmes  
 Address 2538 Sycamore Ave

17. (Burial, cremation, or removal. Which?) B Date thereof 8-2-48  
 (month) (day) (year)

Cemetery or crematory Int. Calvary  
 Location A. A. Co.

16. Funeral director Samuel W. Sullivan Jr  
 Address 1011 N. Arlington Ave + Balto

19. aug 3 19 48 A. W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 2<sup>nd</sup> 1948 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2<sup>nd</sup> 1948 to August 2<sup>nd</sup> 1948 and that I last saw him alive on August 2<sup>nd</sup> 1948

Immediate cause of death asphyxiation and  
Congestion DURATION 10 min.

Due to  
 Due to  
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Dr. Thomas M. D. or other  
 Address Drum St Date signed 8/3/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08124

FILM No. G 117 SEP -2 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:  
County Balto.  
City or town Dundalk 22  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
2506 Grey Manor Terrace  
How long in hospital or institution? SEVEN YRS.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State MD County Balto.  
City or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2506  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME  
Mabel Mabel House

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or Fenton L. House

7. Birth date of deceased (mo., day, yr.) Sept 18-1901 6. (c) If alive, give age 47 years

8. AGE: Years 46 Months 11 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace JAEGER TOWN, N. PENNSYL.  
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business \_\_\_\_\_

12. Name SAMUEL B. MYERS

13. Birthplace PENNSYLVANIA

14. Maiden name ABBIE SWITZER

15. Birthplace PENNSYLVANIA

16. Informant FENTON L. H.

Address 2506 GREY MANOR TERRACE

17. BURIAL Date thereof AUG 30 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory LIND MEMORIAL CEMETERY

Location LEWISTOWN, PENNSYLVANIA

18. Funeral director Roland L. Fisher

Address 2112 Dundalk Ave.

19. Aug 28 19 48 William M. Kelly  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1948 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death Coronary occlusion

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William M. Kelly

Address Balto, Dundalk

Date Signed 9/27/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 28 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 64 days

Hospital, institution, or street address where death occurred:

Veterans Administration HospitalHow long in hospital or institution? 64 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 509 N. Bond Street

(If rural, give LOCATION)

2.(a) If veteran, name war WW I ✓

## 3. (a) FULL NAME

FRANK HUGHES

## 3. (b) Social Security Number

216-03-4085

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male Colored Single6.(b) Name of husband or wife Single

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1, 18978. AGE: Years Months Days If less than one day  
51 7 25 hrs. min.9. Birthplace Deale's Island, Md.  
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name George Hughes13. Birthplace Maryland14. Maiden name Mary Barkley15. Birthplace Maryland16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Md.17. Burial Date there Aug. 30, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Md.18. Funeral director Elroy WilsonAddress 1510 Orleans St., Balto., Md.19. August 30, 1948 A. W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1948 at 3:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 23 1948 to August 26 1948and that I last saw him alive on August 26 1948

Immediate cause of death

CIRRHOSIS OF LIVER

DURATION

6 mos.Plus

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert T. Parker M.D.

M. D. or other

Address VAH Fort Howard, Md. Date signed 8-26-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully: The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 31

<b>1. PLACE OF DEATH:</b> County..... <u>Baltimore</u> City or town..... <u>Catonsville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... Hospital, institution, or street address where death occurred: <u>9 Edmondson Ridge Rd.</u> How long in hospital or institution?..... <u>24 yrs.</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... <u>Md.</u> County..... <u>Balto.</u> City or town..... <u>Catonsville</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>9 Edmondson Ridge Rd.</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....											
<b>3. (a) FULL NAME</b> <u>LELIA PEARL INGRAM</u>				<b>3. (b) Social Security Number</b> <u>none</u>											
<b>4. Sex</b> <u>female</u>		<b>5. Color or race</b> <u>white</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>widow</u>											
<b>6. (b) Name of husband or wife</b> <u>Atkin M. Ingram</u>				<b>6. (c) If alive, give age</b> ..... years											
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>Feb. 14, 1883</u>				<b>8. AGE:</b> <table border="1"> <tr> <td>Years</td> <td>Months</td> <td>Days</td> <td>If less than one day</td> </tr> <tr> <td><u>65</u></td> <td><u>6</u></td> <td><u>10</u></td> <td>.....hrs. ....min.</td> </tr> </table>				Years	Months	Days	If less than one day	<u>65</u>	<u>6</u>	<u>10</u>	.....hrs. ....min.
Years	Months	Days	If less than one day												
<u>65</u>	<u>6</u>	<u>10</u>	.....hrs. ....min.												
<b>9. Birthplace</b> <u>Chesson, Alabama</u> (Town, county, and state) <b>10. Usual occupation</b> <u>Housewife</u>				<b>11. Industry or business</b>											
<b>FATHER</b>		<b>12. Name</b> <u>Fred Foster</u>		<b>13. Birthplace</b> <u>Alabama</u>		<b>14. Maiden name</b> <u>Unknown</u>									
<b>MOTHER</b>		<b>15. Birthplace</b> <u>19</u>		<b>16. Informant</b> <u>Miss Eleanor Ingram</u>		<b>Address</b> <u>9 Edmondson Ridge Rd.</u>									
<b>17. Burial</b> (Burial, cremation, or removal, Which?) Cemetery or crematory..... <u>Woodlawn Cem.</u> Location..... <u>Woodlawn, Md.</u>				Date thereof..... <u>8/26/48</u> (month) (day) (year)											
<b>18. Funeral director</b> <u>WM. J. TICKNER &amp; SONS</u>				<b>Address</b> <u>Balto., Md.</u>											
<b>19. (Date rec'd by Registrar)</b> <u>Aug 26 19 48</u>				<b>Registrar</b> <u>R. W. Hedrick</u>											

MEDICAL CERTIFICATION	
<b>20. DATE OF DEATH</b> ..... <u>Aug. 24</u> ..... 19 <u>48</u> at <u>10A</u> M	
<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> .....19....., fo.....19..... and that I last saw h..... alive on .....19..... <b>Immediate cause of death</b> ..... <u>Coronary heart disease</u> <b>Due to</b> ..... <u>Cardiovascular disease</u> <b>Other conditions</b> ..... (Include pregnancy within 3 months of death) <b>Major findings of operations</b> ..... .....Date of op. .... <b>Autopsy results</b> ..... <b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>	
<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b> Accident, suicide, or homicide..... Date of ..... Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?	
<b>23. SIGNATURE</b> ..... <u>Dr. M. Kieffer</u> M. D. or other Address..... <u>1010 Leaden</u> Date signed <u>8-24-48</u>	

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

### 1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:

Veterans Administration Hospital

How long in hospital or institution? 11 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1119 Darley Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war WW 1

### 3. (a) FULL NAME

JOHN A. JAMISON (JOHN ANDREW JAMISON)

### 3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 18, 1888

8. AGE: Years 59 Months 7 Days 15 It less than one day hrs. min.

9. Birthplace Baltimore, Md.  
(Town, county, and state)

10. Usual occupation Plumber

11. Industry or business

12. Name Andrew Jamison

13. Birthplace Baltimore, Md.

14. Maiden name Mary Griffen

15. Birthplace Baltimore, Md.

16. Informant Clinical Records, Vet. Adm. Hosp.

Address Fort Howard, Md.

17. Burial Date thereof 8/5/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Cathedral Cemetery

Location Baltimore, Md.

18. Funeral director HENRY SANDER & SONS, INC.

Address North Ave. & Broadway, Balto. Md.

19. August 4, 1948 A. W. Heibel  
(Date and by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 1948 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22, 1948 to August 2, 1948

and that I last saw him alive on August 2, 1948

Immediate cause of death DISSEMINATED LUPUS ERYTHEMATOSIS DURATION 4 mos.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.C. MANAUGH, M.D., CHIEF, PROFESSIONAL SERV

Address VAH, Fort Howard, Md. Date signed 8/2/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08127

153

me

44

I

T

28



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

08128

4X

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Fort Howard, MarylandHow long in hospital or institution? 31 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1305 N. Gilmore St.

(If rural, give LOCATION)

2.(a) If veteran, name war

WW I

## 3. (a) FULL NAME

ORIE JOHNSON

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Lena Johnson6. (c) If alive, give age 48 years

## 7. Birth date of

deceased (mo., day, yr.) 10-6-96

## 8. AGE:

Years

Months

Days

If less than one day

51101

hrs.

min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual occupation Porter

## 11. Industry or business

12. Name William Johnson13. Birthplace Baltimore, Maryland14. Maiden name Josephine Harris15. Birthplace Cambridge, Maryland16. Informant Clinical Records, Vets. Adm. HospitalAddress Fort Howard, Maryland17. Burial  
(Burial, cremation, or removal. Which?)Date thereof Aug 12 48  
(month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director Isaiah Brown & SonAddress 108 W. Montgomery St19. 8/9 19 48  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 19 48 at 10:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 7 19 48 to August 7 19 48and that I last saw him alive on August 7 19 48Immediate cause of death CChronic Nephritis

DURATION

UnknownDue to Unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Paul O. Anderson, M.D.Address Paul O. Anderson, M.D.VAH, Ft. Howard, Md.Date signed 8/8/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3/

08129

93c

1. PLACE OF DEATH:  
 County Balto.  
 City or town Randallstown,  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Baltimore Co.  
 City or town Baltimore-7  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3705 Patterson Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

3. (a) FULL NAME John M. Jones (John Minsker Jones)  
 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced widower  
 6.(b) Name of husband or wife Mary E. Jones  
 6.(c) If alive, give age years  
 7. Birth date of deceased (mo., day, yr.) Sept. 2, 1872  
 8. AGE: Years 75 Months 10 Days 29 If less than one day hrs. min.

9. Birthplace Baltimore Co., Md.  
 (Town, county, and state)  
 10. Usual occupation Carpenter - retired  
 11. Industry or business

12. Name William Jones  
 13. Birthplace Unknown  
 14. Maiden name Liza Riley  
 15. Birthplace Md.

16. Informant Mr. Joseph Schwind  
 Address 3705 Patterson Ave.

17. Burial Date thereof 8/4/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Hereford Baptist Cem.  
 Location Hereford, Md.

18. Funeral director WILLIAM J. TICKNER & SONS  
 Address Balto., Md.

19. Aug 3 19 48 A.W. Hylbert  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 19 48 at 10:20 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-1-48 to 8-1-48 and that I last saw her alive on not seen alive

Immediate cause of death Rheumatic C.V. Disease DURATION 3 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

NONE Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? NONE  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. D. Caples, M.D., Med. Exam.  
 M. D. or other

Address Reisterstown, Md. Date signed 8-2-48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Approximately 27 Hrs.

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, MarylandHow long in hospital or institution? Approximately 27 Hrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3437 Lyndale Avenue  
(If rural, give LOCATION)2. (a) If veteran, name war WW I

## 3. (a) FULL NAME

ANDREW G. KEMMERZELL

## 3. (b) Social Security Number

215-10-8899

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteMarried6. (b) Name of husband or wife Elizabeth Kemmerzell6. (c) If alive, give age 49 years7. Birth date of deceased (mo., day, yr.) 7-16-998. AGE: Years Months Days If less than one day  
49 1 13 ..... hrs. .... min.9. Birthplace Baltimore, Maryland  
(Town, county, and state)10. Usual occupation Unemployed

## 11. Industry or business

12. Name Anton Kemmerzell13. Birthplace Germany14. Maiden name Minnie Keehler15. Birthplace Germany16. Informant Clinical Records, Vets. Adm. HospitalAddress Fort Howard, Maryland17. Burial Date thereof 9/2/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director William Cook, Inc.Address Balto., Md.19. Aug 21 19 48 A. W. Keehler  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 19 48 at 11:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 28, 19 48 to August 29, 19 48and that I last saw him alive on August 29, 19 48Immediate cause of death Cardiac hypertrophy and dilatation with pulmonary edemaDue to Rheumatic Heart Disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. ManaghH. C. MANAGH, M.D. Chief Pro. M. Ser.Address VAH, Ft. Howard, Md. Date signed 8-30-48

08130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate exact age especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

08131

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Cockeysville Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months  
 Hospital, institution, or street address where death occurred:  
Masonic Home, Cockeysville Md  
 How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County .....

City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3108 Walbrook Ave  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war .....

## 3. (a) FULL NAME

Charles Warner King

## 3. (b) Social Security Number

215-10-4450 A

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife Mamie A. Bell

7. Birth date of deceased (mo., day, yr.) July 12 - 1880 6. (c) If alive, give age ..... years

8. AGE: Years 68 Months 1 Days ..... If less than one day ..... hrs. .... min.

9. Birthplace Baltimore Md  
 (Town, county, and state)

10. Usual occupation Machinist

11. Industry or business Md. Dry Dock Co -

FATHER

12. Name Charles T. King

13. Birthplace Baltimore Md

MOTHER

14. Maiden name Mamie A. Bell

15. Birthplace Baltimore Md

16. Informant Laura M. Schroeder  
 Address Masonic Home, Cockeysville Md

17. Burial Date thereof Aug. 13 - 48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Linden Plc

Location Baltimore Md

18. Funeral director Wm. Cook  
 Address St. Paul & Preston St

19. Aug 12<sup>th</sup> 19 48 Laura M. Schroeder  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 19 48 at 8:40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8 19 48 to Aug. 11 19 48 and that I last saw him alive on Aug. 11 19 48

Immediate cause of death Heart Failure, Arterio-sclerotic Cardiovascular disease 7 days  
generalized

Due to Arterio-sclerosis

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

..... Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

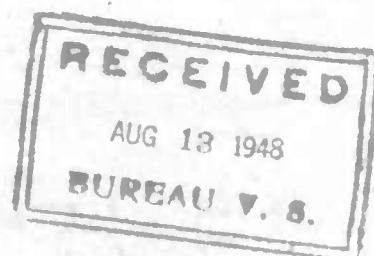
Accident, suicide, or homicide .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE Walter T. Keen M.D. M. D. or other  
 Address Cockeysville Md Date signed 8/11/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

## 1. PLACE OF DEATH

County BaltimoreCity or town Long Green  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltoCity or town Long Green  
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Anna Hoen Kirkwood

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Frank C. Kirkwood

7. Birth date of deceased (mo., day, yr.)

April 8 - 1862

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

86413

hrs.

min.

9. Birthplace

Waverly - Baltimore  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

FATHER

12. Name

Henry Hoen

13. Birthplace

Germany

MOTHER

14. Maiden name

Mary F. Hoen

15. Birthplace

Ireland

16. Informant

Dr. J. F. Hutter

Address

Hydes Rd.

17. (Burial, cremation, or removal, Which?)

Date thereof

Aug 24 - 48  
(month) (day) (year)

Cemetery or crematory

Long Green Cem

Location

Long Green

18. Funeral director

John Burns & son

Address

Long Green

19. (Date rec'd by Registrar)

Registrar

23. SIGNATURE

Address

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21st 19 48 at 1:59 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 20 19 46 until Aug 21 19 48and that I last saw him alive on August 21 19 48

Immediate cause of death

Cerebral Hemorrhage

DURATION

3 day

Due to

cardiac insufficiency

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Data signed

RECEIVED

SEP 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. No correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

08133

## 1. PLACE OF DEATH

County BaltimoreCity or town Sparks Pt. - 19  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County Balt.City or town Sparks Pt. - 19  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2 Oak Road.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

John S. Koporec.

## 3. (b) Social Security Number

## 4. Sex

m

## 5. Color or race

wh.

## 6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife TELKA

## 7. Birth date of deceased (mo., day, yr.)

1871

## 6. (c) If alive, give age years

## 8. AGE:

77

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace Czechoslovakia  
(Town, county, and state)10. Usual occupation retired

## 11. Industry or business

## FATHER

## 12. Name

FRANK KOPOREC

## 13. Birthplace

CZECHOSLOVAKIA

## MOTHER

## 14. Maiden name

HELEN VICEK

## 15. Birthplace

CZECHOSLOVAKIA

## 16. Informant

Telka Koporec

## Address

2 Oak Road.

## 17. Burial

(Burial, cremation, or removal, Which?)

## Date thereof

Aug 31 / 48  
(month) (day) (year)

## Cemetery or crematory

St Stanislaus Cemetery

## Location

Dundalk Ave

## 18. Funeral director

## Address

John F Duda  
2829 Hudson St

## 19. Aug 30 19 48

Q. W. Hedrick  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 19 48 at 10:50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Carcinoma of Stomach

## DURATION

18 m.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. B. Davis M.D.  
Dep. Med. Examiner - Baltimore  
Dundalk Ave Date signed 8/31/48



1948  
77  
1671

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

## 1. PLACE OF DEATH:

County... BaltimoreCity or town... Randallstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Liberty & Old Court Roads

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... BaltimoreCity or town... Randallstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. Liberty & Old Court Roads  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Elmer F. Krider

## 3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Male</u>	<u>White</u>	<u>Single</u>

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 15, 1875

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>5</u>	<u>7</u>	.....hr. ....min.

9. Birthplace... Randallstown, Md.  
(Town, county, and state)10. Usual occupation... Farmer

11. Industry or business

12. Name... Jacob Krider13. Birthplace... Randallstown, Md.14. Maiden name... Elizabeth Kirk15. Birthplace... Hebbville, Woodlawn, Md.16. Informant... Mr. Edgar EulerAddress... Liberty & Old Court Rd., Randallstown17. Burial Date thereof... Aug. 25, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematorium... St. Olive CemeteryLocation... Randallstown, Md.18. Funeral director... Wells LamonAddress... 4510 Liberty Heights Ave.19. 8/24 1948 Dr. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... August 22 1948 at 11.15P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1948 to Aug 22 1948 and that I last saw him alive on Aug 22 1948Immediate cause of death... Cerebral Vase accident DURATION 3 weeksDue to... Generalized arteriosclerosis 7 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Thos Y. Allen M.D. M. D. or otherAddress... 4509 Liberty Hgts Ave. Date signed

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:  
County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 years, 3 months, 6 days  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 3 years, 3 months, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Charles County  
City or town Rock Point  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Elizabeth Lancaster

### 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) October 3, 1886

8. AGE: Years 61 Months 10 Days 28 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Rock Point, Maryland  
(Town, county, and state)

10. Usual occupation Musician

11. Industry or business Church

MOTHER FATHER 12. Name Spearman Lancaster

13. Birthplace Maryland

14. Maiden name Valinda Jenkins

15. Birthplace Maryland

16. Informant Hospital records

Address Catonsville 28, Md.

17. burial Date thereof Sept. 3, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Ghost Church

Location Assault, Maryland

18. Funeral director Waldorf Maryland

Address \_\_\_\_\_

19. 8-31-48 Registrar J.E. Harris

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 1948 at 10:55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25, 1945 to August 31, 1948

and that I last saw her alive on August 31, 1948

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Carcinoma of the breast, with multiple metastases indefinite

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings at operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results no post

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, term, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Isadore Tuerk, M.D.

23. SIGNATURE \_\_\_\_\_ M. D. or other \_\_\_\_\_

Address Catonsville-28, Md. Date signed 8-31-48

MARGIN RESERVED FOR BINDING

I

VS A15 9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville 28, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 years, 7 months, 15 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 4 years, 7 months, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town GUNPOWDER FALLS MD.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

MARY ANN LIBERTINI

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced Widow  
 6. (b) Name of husband or wife Louis Libertini  
 7. Birth date of deceased (mo., day, yr.) October 14, 1875  
 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 72 Months 10 Days 7 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Italy  
 (Town, county, and state)  
 10. Usual occupation housewife  
domestic  
 11. Industry or business \_\_\_\_\_  
 12. Name Sebastiano Barbarino  
 13. Birthplace Italy  
 14. Maiden name ?  
Italy  
 15. Birthplace \_\_\_\_\_

18. Informant Hospital Records  
 Address Catonsville 28, Maryland

17. Burial Date thereof Aug. 24 1948  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory St. Joseph  
Fellerton Maryland  
 Location \_\_\_\_\_

18. Funeral director Frank Della Uoe  
 Address 322 S. High St. Baltimore Md.

19. 8/23 xP A. J. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 21, 1948 at 12:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 6, 1944 to August 21, 1948  
 and that I last saw him/her alive on August 21, 1948

Immediate cause of death  
(Terminal) Pneumonia, undiagnosed DURATION 15 hrs.

Due to Arteriosclerotic heart disease indef.

Due to Chronic glomerular nephritis indef.

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results No autopsy  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Isadore Tuerk, M. D.  
 M. D. or other \_\_\_\_\_

Address Catonsville 28, Md. Date signed 8/21/48

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

31

### 1. PLACE OF DEATH:

County Baltimore  
City or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 years  
Hospital, institution, or street address where death occurred:  
4 Beacon Hill Road  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
City or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4 Beacon Hill Road  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Helen - M - Linnbaum

### 3. (b) Social Security Number

217-12-3296

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Francis V Linnbaum  
7. Birth date of deceased (mo., day, yr.) May 19 1916  
8. AGE: Years 32 Months 0 Days 0 If less than one day hrs. min.

9. Birthplace Baltimore Maryland  
(Town, county, and state)

10. Usual occupation Barmaid

11. Industry or business Tavern

12. Name Fred J. Dinsler

13. Birthplace Baltimore Maryland

14. Maiden name Agnes Stenkel

15. Birthplace Baltimore Maryland

16. Informant Francis V. Linnbaum

Address 4 Beacon Hill Road

17. Burial Burial Date thereof August 9 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Baltimore National

Location 5501 Frederick Road

18. Funeral director John J. Cowan & Son

Address 901 Hollins #23

19. August 6 48 2 W. H. H. H.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 19 48 at 10:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 48 to 19 48

and that I last saw alive on 19 48

Immediate cause of death asphyxiation

Due to asphyxiation

Due to asphyxiation

Other conditions suicide

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of Aug 5 48

Where did injury occur? Woodlawn Baltimore (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury gas from range in kitchen Injured at work? no

23. SIGNATURE Dr. M. Kieffer Edwin B. B.

Address 1010 Leach Ave Date signed Aug 5 48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Turners Station, Dundalk  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... Baltimore  
 City or town..... Turners Station, Dundalk  
 (If outside city or town limits, write RURAL and give nearest town)

Street No..... 3 Patapsco Ave.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Vera Mack

## 3. (b) Social Security Number

## 4. Sex

F.

## 5. Color or race

W.

## 6. (a) Single, married, widowed, or divorced

W.

## 6. (b) Name of husband or wife

Louis Mack

## 7. Birth date of

deceased (mo., day, yr.)

January 31, 1895

## 6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

73628

hrs.

min.

## 9. Birthplace

Hungary

(town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

FATHER

## 12. Name

Michael Paragz

## 13. Birthplace

Hungary

MOTHER

## 14. Maiden name

Vera Kovacs

## 15. Birthplace

Hungary

## 16. Informant

Mrs. Elizabeth Alexander

## Address

3002 Dunmore Rd. Dundalk

## 17.

(Burial, cremation, or removal. Which?)

## Date thereof

Aug. 31, 1948

## Cemetery or crematory

Sacred Heart

## Location

German Hill Road

## 18. Funeral director

Roland P. Fisher

## Address

2112 Dundalk Ave.

## 19.

(Date registered by registrar)

August 30, 1948William M. Frey

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 28th 19... 48 at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....

July 14, 1947 to..... August 28th 19... 48and that I last saw him..... alive on..... August 28th 19... 48

## Immediate cause of death

Bilateral lobar pneumonia

## DURATION

3 days

## Due to

arteriosclerotic gangrene2 months

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

William M. Frey

M.D. or other

Address

Baltimore St.

Date signed

8/30/48



RECEIVED

AUG 31 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

102 N. Colling Rd

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 102 N. Colling Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Ethel Pauline Mahon

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

W.

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

John A. Sr.

## 7. Birth date of

deceased (mo., day, yr.)

May 27-1877

## 6. (c) If alive, give age

years

## 8. AGE:

Years 71Months 2Days 21

If less than one day

hrs.

min.

## 9. Birthplace

Selma, Ala.  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

## FATHER

## 12. Name

Jacob

## 13. Birthplace

Germany

## MOTHER

## 14. Maiden name

Jane Pickens

## 15. Birthplace

S. Carolina

## 16. Informant

Mr. John A. Mahon Jr.

## Address

1910 Sulgrave Ave

## 17.

(Burial, cremation, or removal. Which?)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

Wm. J. Tigency & SonsNorth & A. Aves

## 19.

(Date rec'd by registrar)

8/1819 48V.E. Harry

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18/48 at 48 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/1 19 48 to 8/18 19 48  
and that I last saw her alive on 8/16/48 19 48

Immediate cause of death

Cerebral Hemorrhage

Due to

High Blood Pressure

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Lloyd Johnson  
Catonsville, Md. M. D. or other  
Date signed 8/18/48

RECEIVED  
AUG 20 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County 275 Baltimore Ave  
 City or town Dundalk Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md CountyCity or town Dundalk Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 275 Baltimore Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

CORONA MARCOMIN

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife Carlo Marcomin

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8 18788. AGE: Years Months Days It less than one day  
70 1 21 hrs. min.9. Birthplace Fratapolesine - Rovigo Italy  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Eugenio Santato13. Birthplace Italy14. Maiden name Pasqua Boldrin15. Birthplace Italy16. Informant Carlo Marcomin HusbandAddress 275 Baltimore Ave17. Burial Date thereof Sept. 1st 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory ST. STANISLAUSLocation MT. CARMEL RD.18. Funeral director Frank Della RoseAddress 322 S. High St.19. Aug 31 19 48 Dr. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH August 29 19 48 at 4:55 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19 45 to Aug 29 19 48  
and that I last saw him alive on Aug 29 19 48

Immediate cause of death

myocarditis acuta

DURATION

1 week

Due to

diabetes mellitus10 yrs

Due to

Carcinoma left breast9 mos.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

David H. Andrew M.D.Address 2 Wm. St. Dundalk Md Date signed Aug 30, 1948

...Date signed... 8/23/4...

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 34

08142

## 1. PLACE OF DEATH

County BaltimoreCity or town Brownleeburg  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Brownleeburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Ethel M Marshall

## 3. (b) Social Security Number

✓

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M.6. (b) Name of husband or wife J. Wheeler Marshall6. (c) If alive, give age 45 years7. Birth date of deceased (mo., day, yr.) Jan 23 - 19048. AGE: Years 44 Months 6 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation St. Prof.

11. Industry or business

12. Name Isaac M. Wheeler13. Birthplace Maryland14. Maiden name Alvada T. Amason15. Birthplace Maryland16. Informant J. Wheeler MarshallAddress Upper Md17. Burial Date thereof Aug 7 - 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory HampsteadLocation Carroll Co. Ind18. Funeral director Edw. C. TiptonAddress Hampstead Md19. 8-5- 19 48 Mary B. Eline

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4, 19 48 at 5 P. M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 11, 19 46, to Aug 4, 19 48and that I last saw him alive on Aug 4 - 19 48Immediate cause of death Primary Carcinomaof the breastDue to Generalized Carcinomaespecially of lungs

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

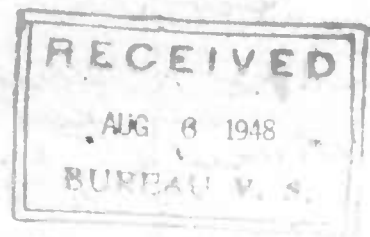
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Edw. M. Bush M. D.Hampstead Md Date signed 8-4-48





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Middle River  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death: Long Fall Nursing Home

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State BaltimoreCity or town Middle River  
(If outside city or town limits, write RURAL and give nearest town)Street No. 18  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

JAMES B. MATHERLY

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife INDIA

7. Birth date of deceased (mo., day, yr.)

India 6. (c) If alive, give age May 22, 1902 years

8. AGE:

Years

Months

Days

If less than one day

46

3

9

hrs.

min.

9. Birthplace WEST VIRGINIA

(Town, county, and state)

10. Usual occupation AUTO MECHANIC

11. Industry or business

FATHER

12. Name WILLIAM Matherly

MOTHER

13. Birthplace ?14. Maiden name ?15. Birthplace ?16. Informant ROBERT L. MATHERLY - SONAddress 7 EDGEWATER APTS17. (Burial, cremation, or removal) FuneralDate thereof 9/1/48  
(month) (day) (year)Cemetery or crematory ChesapeakeLocation West Virginia18. Funeral director William L. BrownAddress 1214 H. Court19. Sept 1 19 48 A. W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 19 48 at 10:40 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 24 19 47 to Aug 31 19 48and that I last saw ? alive on Aug 31 19 48

Immediate cause of death

Broncho Pneumonia

DURATION

2 days

Due to

Pulmonary fibrosis5 years

Due to

chronic bronchial asthma15 years

Other conditions

Chronic pulmonary  
et heart failure

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE William KolodnyM. D. OtherAddress 45 Edgewater Apt Date signed Sept 1, 1948

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08143

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

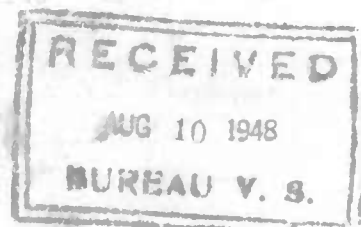
## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH:</b> County <u>Baltimore</u> City or town <u>Fort Howard, Maryland</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>30 days</u> Hospital, institution, or street address where death occurred: <u>Vets. Adm. Hospital, Fort Howard, Maryland</u> How long in hospital or institution? <u>30 days</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Baltimore</u> City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>14 W. 24th St., Baltimore 18, Md.</u> (If rural, give LOCATION) 2.(a) If veteran, name war <u>P.I.</u>			
<b>3. (a) FULL NAME</b> <u>Charles May</u> (Also known as <u>Paul Foust</u> )				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>Male</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Widowed</u>			
<b>6. (b) Name of husband or wife</b>							
<b>6. (c) If alive, give age</b> ..... years							
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>June 26, 1879</u>							
<b>8. AGE:</b> Years <u>69</u>		Months <u>1</u>		Days <u>11</u>		If less than one day ..... hrs. .... min.	
<b>9. Birthplace</b> <u>Lancaster, Pa.</u> (Town, county, and state)							
<b>10. Usual occupation</b> <u>Stone Cutter</u>							
<b>11. Industry or business</b>							
<b>FATHER</b> 12. Name <u>George May</u> 13. Birthplace <u>Pennsylvania</u>							
<b>MOTHER</b> 14. Maiden name <u>Hannah King</u> 15. Birthplace <u>Pennsylvania</u>							
<b>16. Informant</b> <u>Clinical Records, Vets. Adm. Hospital</u> Address <u>Fort Howard, Maryland</u>							
<b>17. removal</b> Date thereof <u>August 8, 1948</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Greenmount Cemetery</u> Location <u>York, Pa.</u>							
<b>18. Funeral director</b> <u>A. F. Koller</u> Address <u>York, Pa.</u>							
<b>19.</b> <u>8/10</u> <u>48</u> <u>A. W. Hedrick</u> (Date rec'd by registrar) 19..... Registrar							
<b>MEDICAL CERTIFICATION</b> <b>20. DATE OF DEATH</b> <u>August 7, 1948</u> <u>10:20 P.</u>							
<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>July 9</u> <u>1948</u> <u>1m</u> <u>alive on August 7, 1948</u> and that I last saw h..... Immediate cause of death <u>Myocardial infarction</u> DURATION <u>10 min.</u>							
Due to <u>Arteriosclerotic heart disease with coronary occlusion</u> Due to..... Other conditions..... (Include pregnancy within 8 months of death) Major findings of operations..... Date of op. ....							
Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.							
<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....							
<b>23. SIGNATURE</b> <u>Paul O. Anderson, M.D.</u> <u>Fort Howard, Maryland</u> <u>Aug 8 '48</u> Address..... Date signed.....							



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months 24 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 26 South Schroeder Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Martin McConville

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Separated?  
 6. (b) Name of husband or wife Willie Parks  
 6. (c) If alive, give age 2 years  
 7. Birth date of deceased (mo., day, yr.) November 21, 1892  
 8. AGE: Years 55 Months 8 Days 25 If less than one day hrs. min.  
 9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation Produce dealer  
 11. Industry or business Middleman  
 12. Name Joseph McConville  
 13. Birthplace Baltimore, Md.  
 14. Maiden name Delia Hayes  
 15. Birthplace Baltimore, Md.

16. Informant Hospital records  
 Address Catonsville, 28, Md.  
 17. Burial Date thereof August 18-1948  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory Balto National Cemetery  
 Location Balto Md  
 18. Funeral director Robt & B.M. Walker  
 Address Pratt & Stucky St  
 19. 8-17-48 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1948 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22, 1948 to August 15, 1948  
 and that I last saw him alive on August 15, 1948

Immediate cause of death Terminal pneumonia DURATION 24 hours

Due to Laennec's cirrhosis Indefinite

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadora Tuerk, M.D. M. D. or other

Address Catonsville, 28, Md. Date signed 8/15/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08146

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County Balto.  
City or town Towson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

510 W. Joppa Rd.

How long in hospital or institution?

6 yrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Towson  
(If outside city or town limits, write RURAL and give nearest town)Street No. 510 W. Joppa Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

ROSALIE M. MECREDDY

## 3. (b) Social Security Number

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>		
6. (b) Name of husband or wife <u>James R. McCreedy</u>				
7. Birth date of deceased (mo., day, yr.) <u>Apr. 21, 1888</u>				
8. AGE: Years <u>60</u>	Months <u>4</u>	Days <u>10</u>	It less than one day ..... hrs. .... min.	

9. Birthplace Roanoke, Va.  
(Town, county, and state)10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name Thomas W. Miller13. Birthplace Va.14. Maiden name Ida Digges15. Birthplace Va.16. Informant Mr. James R. McCreedyAddress 510 W. Joppa Rd.17. Removal 9/2/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Evergreen Cem.,Location Roanoke, Va.18. Funeral director WM. J. TICKNER & SONSAddress Balto., Md.19. Sept 1 19 48 G. W. G. G. G. Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 19 48 at 1:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 1945 to Aug. 31 19 48and that I last saw him alive on Aug. 30 19 48Immediate cause of death Acute Coronary InsufficiencyDue to Chr. Coronary Insufficiency June 1948Due to Hypertensive cardio-vascular disease 2 1/2 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. J. Shallock, M.D. M. D. or otherAddress 200 W. Plume Rd. Date signed 8/31/48Towson 4, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

### 1. PLACE OF DEATH:

County Balto  
City or town RFD 1, Cocheysville, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County Balto  
City or town Cocheysville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. RFD 1  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Henry Curtis Miller

### 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced widowed  
6. (b) Name of husband or wife Mary Ellen Miller  
6. (c) If alive, give age 40 years  
7. Birth date of deceased (mo., day, yr.) March 23, 1868  
8. AGE: Years 80 Months 45 Days 3 If less than one day  
hrs. min.

9. Birthplace Balto Co. Md.  
(Town, county, and state)

10. Usual occupation Painter

11. Industry or business

12. Name George W. Miller

13. Birthplace Balto Co. Md.

14. Maiden name Mary Frederick

15. Birthplace Johnstown Pa.

16. Informant Miss Irene Miller

Address RFD 1, Cocheysville, Md.

11. (Burial, cremation, or removal, which?) Burial Date thereof 8-29-48  
(month) (day) (year)

Cemetery or crematory Poplar Grove

Location Cocheysville Md.

18. Funeral director J. Scott Brooks

Address Sparks, Md.

19. 8-28 19 48 Wilmer C. Ensor  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 19 48 at 9:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 46 to Aug 26 19 48

and that I last saw him alive on Aug 25 19 48

Immediate cause of death Acute coronary thrombosis DURATION 1 day

Due to arteriosclerosis 10 yrs.  
+ moderate hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations. Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Elizabeth B. Samuel, M.D. M. D. or other  
Address Cocheysville, Md. Date signed 8/26/48

MARGIN RESERVED FOR BINDING

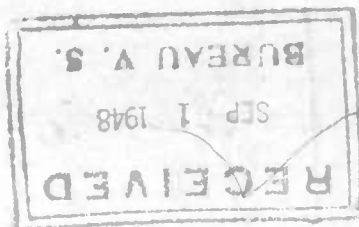
VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08147

94a







PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**MARYLAND STATE DEPARTMENT OF HEALTH**

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH:</b> County..... City or town..... (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... Hospital, institution, or street address where death occurred: How long in hospital or institution?.....					<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... County..... City or town..... (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2.(a) If veteran, name war.....				
<b>3. (a) FULL NAME</b>  					<b>3. (b) Social Security Number</b>  				
4. Sex		5. Color or race		6. (a) Single, married, widowed, or divorced					
7		W		Married					
6. (b) Name of husband or wife									
Best H Morrison									
7. Birth date of deceased (mo., day, yr.)									
June 6 1908									
8. AGE:      Years      Months      Days      if less than one day									
46		5		25		hrs.			
9. Birthplace									
Baltimore Md									
10. Usual occupation									
Housewife									
11. Industry or business									
Henry Jarman									
12. Name									
13. Birthplace									
Baltimore Md									
14. Maiden name									
Anna Young									
15. Birthplace									
Columbia Pa									
16. Informant									
Reed Relay Sanclain									
Address									
Relay Md									
17. BURIAL      Date thereof      SEPT 4 1948									
(Burial, cremation, or removal. Which?)      (month) (day) (year)									
Cemetery or crematory									
LOUDON PARK									
Location									
3801 FREDERICK AVE									
18. Funeral director									
Harry N Witche									
Address									
4101 Edmondson Ave									
19. Sept 1 1948      A.W. Hedrick      Registrar									
(Date rec'd by registrar)      of      Registrar									

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

XX

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 68 days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp. Fort Howard, Md.  
 How long in hospital or institution? 68 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4703 Walther Blvd  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war VV-1

## 3. (a) FULL NAME

NAGLE, Hiester M. (HIESTER M. NAGLE)

## 3. (b) Social Security Number

212-01-6531

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 8.(b) Name of husband or wife Maud Nagle  
 7. Birth date of deceased (mo., day, yr.) January 8, 1888 8.(c) If alive, give age 58 years  
 8. AGE: Years 60 Months 7 Days 13 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Reading, Pa.  
 (Town, county, and state)  
 10. Usual occupation unemployed  
 11. Industry or business \_\_\_\_\_  
 12. Name Hiester Nagle  
 13. Birthplace Pa.  
 14. Maiden name Lucretia Boyer  
 15. Birthplace Pa.

16. Informant Clinical Records, Vets. Adm. Hosp.  
 Address Fort Howard, Maryland  
 17. Burial Date thereof 8-25-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Moreland Memorial Cemetery  
 Location Baltimore, Md.  
 18. Funeral director H. Sander & Sons  
 Address Broadway & North Ave., Balto., Md.  
 19. 8/23 19 48 AW. Wedel  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 19 48 at 1:55 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 14, 19 48 to August 21 19 48  
 and that I last saw him alive on August 21 19 48  
 Immediate cause of death PYELONEPHRITIS  
 Due to Carcinoma of Prostate with obstruction of Ureters  
 Due to \_\_\_\_\_  
 Other conditions None  
 (Include pregnancy within 3 months of death)

DURATION  
UnknownUnknown

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results Substantiated Above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Milton Sander M. D. or other \_\_\_\_\_  
 Address VAH FT. Howard, Md. Date signed 8-21-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 08150 30

1. PLACE OF DEATH:  
 County..... 1300 Ridge Road  
 City or town..... Catonsville, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 2 Years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Md. County.....  
 City or town..... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1300 Ridge Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

George E. Nelson

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married  
 Lillian M. Nelson  
 6.(b) Name of husband or wife  
 8.(c) If alive, give age 44 years  
 7. Birth date of deceased (mo., day, yr.) November 7, 1901  
 8. AGE: Years 46 Months 9 Days 19 If less than one day hrs. min.  
 9. Birthplace Baltimore, Md.  
 (Town, county, and state)  
 10. Usual occupation Vice Pres. & Treasurer  
 P.M. Womble Lumber Co.  
 11. Industry or business  
 12. Name George E. Nelson  
 13. Birthplace Baltimore, Md.  
 14. Maiden name Emelia B. Wilhelm  
 15. Birthplace Germany

16. Informant Mrs Lillian M. Nelson  
 Address 1300 Ridge Rd., Catonsville, Md  
 Burial 8-30-48.  
 17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)  
 Cemetery or crematory Loudon Park  
 Location Baltimore  
 18. Funeral director Frederick A. Cole  
 Address 1200 W. Lombard St.  
 19. Aug 31, 1948 A. W. Hegner  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 26th 1948 at M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1947 to Aug 26 - 1948  
 and that I last saw him alive on Aug 26 - 1948

Immediate cause of death Coronary Thrombosis  
 Due to Hypertensive Arterio Sclerosis  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Robert C. Nitch M. D. or other  
 Address 2151 W. Illinois Ave Date signed 8/27/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

08151

28

## 1. PLACE OF DEATH:

County Baltimore  
City or town Rural - Baltimore - Rodgers Forge  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore  
City or town Baltimore - Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 812 Regester Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war

NO

## 3. (a) FULL NAME

LOUIS OHLGART

## 3. (b) Social Security Number

NONE

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife Margaret C. Kohlhepp

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) September 20, 1865

8. AGE: Year 82 Months 10 Days 23 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)

10. Usual occupation Lithographer - Retired11. Industry or business A. Hoen & Co.12. Name Philip Ohlgart13. Birthplace Germany14. Maiden name Margaretha Engel15. Birthplace Germany16. Informant Mrs. James W. Bradburn - daughterAddress 1713 Windemere Avenue - 18Burial 8/14/4817. (Burial, cremation, or removal, which) Baltimore CemeteryCemetery or crematory Baltimore, MarylandLocation HENRY SANDER & SONS, INC.18. Funeral director NORTH AVE. & BROADWAYAddress 813 x 819. (Date rec'd by registrar) 8/13/48Registrar AW Hedrick

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 12, 1948 at 1.30A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Sept 25 1947 to Aug 12 1948  
and that I last saw him alive on Aug 11 1948

Immediate cause of death Left leg  
Jeune's thrombosis DURATION 2 days

Due to Cancer of Prostate Gland 13 yrs

Due to Recurrent Metastases 2 yrs

Other conditions Widespread Colon Cancer Aug 10/48

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Prostate  
Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W H May Jr M. D. or otherAddress 1520 E. 33rd St Date signed 8/13/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

186a

Reg. Dist. No.

08152

30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 years, 10 months, 10 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 4 years 10 months 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford  
 City or town Aberdeen  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. County Home  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war W ✓

## 3. (a) FULL NAME

Margaret Oliver

## 3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife  
 7. Birth date of deceased (mo., day, yr.) November 15th 1856  
 8. AGE: Years 91 Months 8 Days 30 It less than one day hrs. min.

9. Birthplace Ireland  
 (Town, county, and state)  
 10. Usual occupation Dressmaker  
 11. Industry or business Clothing  
 12. Name James Oliver  
 13. Birthplace Ireland  
 14. Maiden name Jane Elliott  
 15. Birthplace Ireland

16. Informant Hospital records  
 Address Catonsville, 28, Maryland  
Funeral Date thereof 8/17/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematorium London Park  
 Location Baltimore MD  
 18. Funeral director William G. G. Inc.  
 Address 1214 St. Paul  
8/16 48  
 19. (Date rec'd by registrar) 19 48 Registrar W

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 14, 1948 19 at 7:15 P M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from before death 19 to after death 19  
 and that I last saw alive on 19  
 Immediate cause of death Acute cardiac dilatation  
 DURATION 48 hours  
 Due to Hypertensive CV Disease Indefinite  
Arteriosclerotic C V " "  
 Due to fracture right ankle  
 Other conditions accident  
 (Include pregnancy within 3 months of death)  
 Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide accident Date of July 28, 48  
 Where did injury occur? Catonsville Md (City or town) (State)  
 Injured at home, farm, industry, public place (where?) hospital  
 Means of injury slipped on floor, pushed by patient Injured at work? patient  
 23. SIGNATURE Geo. M. Tieffler M. D. or other deputy  
 Address 1010 Deeds Ave Date signed Aug 14-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

<b>1. PLACE OF DEATH:</b> County <u>Baltimore</u> City or town <u>Dundalk 22 mo</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>6 yrs.</u> Hospital, institution, or street address where death occurred: How long in hospital or institution? <u>2 months</u>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Baltimore</u> City or town <u>Dundalk 22 mo</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>8126 Long Point</u> (If rural, give LOCATION) 2. (a) If veteran, name war	
<b>3. (a) FULL NAME</b> <u>Miss Esther Marie Palmer</u>		<b>3. (b) Social Security Number</b>	
<b>4. Sex</b> <u>F.</u>	<b>5. Color or race</b> <u>W.</u>	<b>6. (a) Single, married, widowed, or divorced</b> <u>M.</u>	
<b>8. (b) Name of husband or wife</b> <u>Thomas W. Palmer</u>		<b>8. (c) If alive, give age</b> ..... years	
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>September 30, 1909</u>			
<b>8. AGE:</b> <u>38</u>	<b>Months</b> <u>10</u>	<b>Days</b> <u>29</u>	<b>If less than one day</b> ..... hrs. .... min.
<b>9. Birthplace</b> <u>Franklin County, Pa.</u> (Town, county, and state)			
<b>10. Usual occupation</b> <u>Housewife</u>			
<b>11. Industry or business</b>			
<b>FATHER</b>	<b>12. Name</b> <u>Edward F. Spangler</u>		
<b>MOTHER</b>	<b>13. Birthplace</b> <u>Pa.</u>		
<b>14. Maiden name</b> <u>Annie Sollenberger</u>	<b>15. Birthplace</b> <u>Pa.</u>		
<b>16. Informant</b> <u>Thomas W. Palmer</u> Address <u>8126 Long Point Rd., Dundalk, Md.</u>			
<b>17. Burial</b> (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof <u>Aug. 30, 1948</u> (month) (day) (year) Cemetery or crematory <u>Oaklawn</u> Location <u>7225 Eastern Ave.</u>			
<b>18. Funeral director</b> <u>Poland R. Fisher</u> Address <u>2112 Dundalk Ave.</u>			
<b>19. Aug 28 19 48</b> (Date rec'd by registrar) <u>William M. Kelly Jr.</u> Registrar			
<b>MEDICAL CERTIFICATION</b>			
<b>20. DATE OF DEATH</b> <u>August 27<sup>th</sup> 1948</u> at <u>6:05 PM</u>			
<b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>October 1946</u> to <u>August 27<sup>th</sup> 1948</u> and that I last saw him alive on <u>Aug 26<sup>th</sup> 1948</u>			
<b>Immediate cause of death</b> <u>uterine Carcinoma</u>			
<b>DURATION</b> <u>2 years</u>			
<b>Due to</b> .....			
<b>Due to</b> .....			
<b>Other conditions</b> .....			
(Include pregnancy within 3 months of death)			
<b>Major findings of operations</b> .....			
Date of op. ....			
<b>Autopsy results</b> .....			
<b>PHYSICIAN:</b> Please underline the cause to which death should be charged statistically.			
<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following:			
Accident, suicide, or homicide ..... Date of .....			
Where did injury occur? ..... (City or town) (County) (State)			
Injured at home, farm, industry, public place (where?) .....			
Means of injury ..... Injured at work? .....			
<b>23. SIGNATURE</b> <u>J. H. Thomas MD</u> M. D. or other Address <u>Gurners St. Md.</u> Date signed <u>8/27/48</u>			

CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS

MEDICAL CERTIFICATION

RECEIVED  
AUG 28 1948  
BUREAU V. B.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 169H

## 1. PLACE OF DEATH:

- (a) Baltimore City, Maryland  
 (b) Street address The Terraces, Mt. Wash.  
 (c) Hospital or institution: none  
 (d) Length of stay in hospital or inst. (yrs., mo., or days)  
 (e) Length of stay in Baltimore (yrs., mo., or days) 25 yrs.

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Baltimore  
 (c) City or town Mt. Washington, Balto., 9  
 (If outside city or town limits, write RURAL and give town)  
 (d) Street No. The Terraces (If rural give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

## 3 (a) FULL NAME

Walter A. Patrick

## 3 (b) If veteran, name war

## 3 (c) Social Security Account No.

4. Sex male 5. Color or race white 6 (a) Single, married, widowed, or divorced. widowed

- 6 (b) Name of husband or wife Mary Manning  
 6 (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)
- November 19, 1862

8. AGE: Years 85 Months 9 Days 11 If less than one day  
 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Onandago Co., N. Y.  
 (Town, county, and state)

10. Usual Occupation
- blacksmith

11. Industry or business
- retired 25 years

12. Name
- Fairfield Patrick

13. Birthplace
- Sherburn, N. Y.

14. Maiden Name
- Mary Fitzsimmons

15. Birthplace
- Dublin, Ireland

- 16 (a) Informant
- Walter A. Patrick, Jr.

- (b) Address
- The Terraces, Mt. Wash.

- 17 (a) Burial (b) Date thereof 9/1/48  
 (Burial, cremation, or removal) (month) (day) (year)

- (c) Cemetery New Cathedral  
 Location Old Frederick Road, Baltimore

- 18 (a) Funeral director
- John C. Mitchell & Sons, Inc.

- (b) Address
- 1900 Eutaw Place

- 19 (a) Aug 30-48 a. w. Hedrick  
 (Date registered by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH
- August 30
- 19
- 48
- , at
- 8:45
- A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

## IMMEDIATE CAUSE OF DEATH

Due to Asphyxiation due to illuminating gas

Other Conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

22. If an external cause was primary
- ☒
- or contributing
- ☐
- cause of death, fill in the following:

- (a) Date of injury
- Aug 30 1948 at 8:45
- A.M.

- (b) Where did injury occur?
- The Terraces, Mt. Wash.

- (c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No

- (d) Means of injury
- Flooded head with an open gas burner

23. Signature
- William J. Hedrick
- M.D.

- Date signed
- Aug 30, 1948
- Medical Examiner

- Howard J. Walters, M.D.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 95C

### 1. PLACE OF DEATH:

County BALTIMORE  
City or town RFD 15' Box 638 MIDDLE RIVER  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County BALTIMORE  
City or town RFD 15' B. X 638 MIDDLE RIVER  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

MARY PEACOCK

### 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE WHITE WIDOW

6. (b) Name of husband or wife JOHN PEACOCK

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 25 1966

8. AGE: Years Months Days If less than one day  
82 5 2 ..... hrs. .... min.

9. Birthplace BALTIMORE MD.  
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name WILLIAM HIGDON

13. Birthplace BALTIMORE MD.

14. Maiden name MARY VICKERS

15. Birthplace BALTIMORE MD.

16. Informant MRS MARGARET HENRY

Address RFD 15' Box 638 MIDDLE RIVER

17. BURIAL Date thereof 8/30/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory MT. OLIVET

Location FREDERICK AVE

18. Funeral director WM COOK INC.

Address 1717 ST. PAUL ST.

19. 8/28 48 Registrar Ann K. K...

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 27th 19 48 at 11:15A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 24th 19 48 to 8-27 19 48

and that I last saw or alive on August 26th 19 48

Immediate cause of death Congestive heart failure

DURATION 3 days

Due to Heart disease, chronic non-valvular.

5 yrs

Due to

Other conditions Bronchitis, asthmatic

5 yrs

Bronchitis, acute

7 days

(include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

SIGNATURE Thomas B. Hargley MD

Address 815 Eastern Ave Date signed 8/27/48

Registrar

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

## 1. PLACE OF DEATH:

County Balto.City or town Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 37 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Reisterstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 69 Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

William F. Peltzer

## 3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Gertrude S. Peltzer

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 18668. AGE: Years Months Days If less than one day  
81 8 20 hrs. min.9. Birthplace Balto. Co.  
(Town, county, and state)10. Usual occupation Carpenter

11. Industry or business

12. Name Frank Peltzer13. Birthplace Balto. Co.14. Maiden name Amelia Mort15. Birthplace Balto. Co.16. Informant Mrs. Gertrude S. PeltzerAddress Reisterstown, Md.17. Burial Date thereof Aug. 30, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Druid RidgeLocation Balto. Co.18. Funeral director J. F. Eline - SonsAddress Reisterstown, Md.19. 8-30- 48 Mary B. Eline  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26, 48 19 48 at 4:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 26, 48 19 48, to Aug 26, 1948and that I last saw him dead on Aug 26, 1948

Immediate cause of death

arteriosclerotic C-V. Disease 2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Not Date ofWhere did injury occur? None  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury None Injured at work?23. SIGNATURE J. D. Caples, M.D. Ind. Exam.  
M. D. or otherAddress Reisterstown, Md. Date signed 8-30-48

RECEIVED

SEP 2 1948

RECEIVED V. S.

Birth and Death 08157  
200c

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF STILLBIRTH

Reg. Dist. No. 44

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Baltimore  
City or town Sparrows Point  
(If outside city or town limits, write RURAL and give nearest town)  
Street address, hospital, or institution:  
2506 Lodge Farm Road  
Length of mother's stay in County 1 year  
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State MD  
County Same as #1  
City or town Same as #1  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.                       
(If RURAL give LOCATION)

3. Name of child Lowell Perry  
5. Sex Male | 6. Twin or triplet —

4. Date of birth Aug. 4, 1948 Hour 3:15 P.M.  
7. No. of weeks pregnancy 21

FATHER OF CHILD

8. Full name Alvin Lowell Perry  
9. Color W 10. Age at time of this birth 24 yrs.  
11. Usual occupation Handyman, Shipyard

MOTHER OF CHILD

12. Full maiden name Evelyn Jean Montgomery  
13. Color W 14. Age at time of this birth 15 yrs.  
15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 1  
(b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of None

19. Labor: (a) Complications of None  
(b) Induced? No

20. (a) Was there an operation for delivery? No  
(b) State all operations, if any                       
(Yes or No)

(c) Did child die before operation? No  
During operation? No

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Unknown  
(b) Maternal causes Unknown

22. I certify to the birth of this child who was born dead\*  
on the date and hour above stated. above

Signature Robert E. Farber, M.D.  
(Specify if M. D., midwife, or other)

Address Sparrows Point, Md

23. (a) Burial (Point) (b) Date thereof Aug. 4, 1948  
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory 7302 Waldman Ave

24. (a) Funeral director Alvin Lowell Perry

(b) Address 2506 Lodge Farm Rd., Sp Pk Md

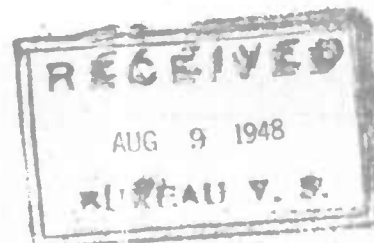
25. (a) 8-4-48 (b) Lawson L. Harber  
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)  
The above certificate has been examined by me.

Health Officer, per.....

\* See Instruction C on stub.

Child lived 3 days



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully, in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: **Baltimore**  
 County **Catonsville**  
 City or town (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **11 years, 8 months, 27 days**  
 Hospital, institution, or street address where death occurred:  
**Spring Grove State Hospital**  
 How long in hospital or institution? **11 years, 8 months, 27 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State **Maryland** County  
 City or town **Baltimore**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. **2207 Christian Street**  
 (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

**Robert Pettie**

3. (b) Social Security Number

4. Sex **Male** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Single**  
 6. (b) Name of husband or wife  
 7. Birth date of deceased (mo., day, yr.) **July 28, 1918** 6. (c) If alive, give age years  
 8. AGE: Years **30** Months **-** Days **7** If less than one day hrs. min.

9. Birthplace **Baltimore**  
 (Town, county, and state)  
 10. Usual occupation **Factory worker**  
 11. Industry or business **Toy**  
 12. Name **William Pettie**  
 13. Birthplace **Virginia**  
 14. Maiden name **Sophia — Supfinger**  
 15. Birthplace **Virginia**

16. Informant **Hospital records**  
 Address **Catonsville, 28, Md.**  
 17. **Burial** Date thereof **Aug. 9, 1948**  
 (Burial, cremation, or removal, Which) (month) (day) (year)  
 Cemetery or crematory **St. Olivet**  
 Location **Baltimore**  
 18. Funeral director **Frederick A. Cole**  
 Address **1200 W. Lombard St.**  
 19. **8/9** **8** **Asst. W. Hedrick**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH **August 7, 1948** at **3:30 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **November 12, 1937** to **August 7, 1948**

and that I last saw him alive on **August 7, 1948**

Immediate cause of death **Acute nephritis, undiagnosed, with anuria**

DURATION  
24 hrs.

Due to **Diabetic acidosis** 36? "

Due to **Diabetes mellitus** Indefinite

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations **Thoracotomy**

Date of op. **1938**

Autopsy results **None**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **Isadore Tuerk, M. D.** M. D. or other

Address **Catonsville, 28, Md.** Date signed **8/7/48**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Essex, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place at death?..... life  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County..... Baltimore.....  
 City or town..... Essex, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Back River & Holly Neck Rds.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

CARRIE S. PETTIT

## 3. (b) Social Security Number

4. Sex..... female..... 5. Color or race..... white..... 6.(a) Single, married, widowed, or divorced..... married.....  
 6.(b) Name of husband or wife..... Burnett A. Pettit..... 6.(c) If alive, give age..... years.....  
 7. Birth date of deceased (mo., day, yr.) March 20th, 1890  
 8. AGE: Years..... 58..... Months..... 5..... Days..... 11..... It less than one day..... hrs. .... min. ....  
 9. Birthplace..... Baltimore County, Md.  
 (Town, county, and state)  
 10. Usual occupation..... at home.....  
 11. Industry or business.....

FATHER 12. Name..... Christopher Selig  
 13. Birthplace..... Germany  
 MOTHER 14. Maiden name..... Unknown  
 15. Birthplace..... Unknown

16. Informant..... Mr. Burnett A. Pettit  
 Address Back River & Holly Neck Rds.,

17. burial Date thereof 9/3/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Oak Lawn  
 Location Eastern Ave.

18. Funeral director..... Assahm Funeral Home  
 Address 7401 Belair Rd.

19. Sept 2 - 48 John E. Connolly  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31st, 1948, at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4, 1948, to Aug 31, 1948, and that I last saw her alive on May 3, 1948.

Immediate cause of death.....

DURATION

Multiple Myelomata of 4 mos.  
 Due to Vertebrae & skull

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Manner of injury Injured at work?

23. SIGNATURE..... Joseph Pokorny M.D.

Address 2200 E Madison St Date signed 8/31/48

RECEIVED

SEP 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County... BALTIMORECity or town... CATONSVILLE  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

BONNIE VIEW NURSING HOME

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD County...City or town... BALTIMORE  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3808 HARLEM AVE  
(If rural, give LOCATION)

2.(a) If veteran, name war...

## 3. (a) FULL NAME

MARGARET A PHILLIPS

## 3. (b) Social Security Number

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED6. (b) Name of husband or wife... Late HARRY

8. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) DEC. 25, 18668. AGE: Years Months Days If less than one day  
81 7 15 hrs. min.9. Birthplace... MARYLAND  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name JAMES SICKNALL13. Birthplace MD.14. Maiden name MARTHA15. Birthplace MD.18. Informant Mrs HELEN LINGEMANAddress 3808 HARLEM AVE17. BURIAL Date thereof AUG 18 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory LOUDON PARKLocation 3801 ELMORE AVE18. Funeral director Mary H. WithAddress 4101 Edmonson Ave19. 8-2 4P 4P  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... AUGUST 15 19 48 at... M21. I CERTIFY that death occurred on the date above stated. That I attended deceased from Aug 1 - 19 48 to Aug 15 19 48and that I last saw him alive on Aug 14 19 48Immediate cause of death Carcinoma of Rectum DURATION 6 moMetastatic

Due to...

Due to...

Other conditions Severe Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ....

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Chas A. CarterAddress 2145 N Balto St M. D. or other 8/17/48

Date signed

Evidence for change of  
birth date shown on:

FILM-No. G 116 AUG 13 1948 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08161

93d

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto. Co.  
City or town Edgemere 2618 Manor Ave  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 36 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Balto.  
City or town Edgemere  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2618 Manor Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Clementina Poplovski

3. (b) Social Security Number

4. Sex Female  
5. Color or race White  
6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Anton  
December 25  
7. Birth date of deceased (mo., day, yr.) July 31 - 1948 1884 1886  
6. (c) If alive, give age 64 years  
8. AGE: Years 62 Months 0 Days 5  
If less than one day  
.....hrs. ....min.

9. Birthplace.....  
(Town, county, and state)  
10. Usual occupation housework  
11. Industry or business  
12. Name ?  
13. Birthplace ?  
14. Maiden name ?  
15. Birthplace ?

16. Informant Anton Poplovski  
Address 2618 Manor Ave  
17. Burial Date thereof 8-9-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Holy Redeemer Cem  
Location Belair Rd  
18. Funeral director Joseph Kasuskas Jr  
Address 602 Washington Bldg  
Aug 6 - 1948 Dawson L. Farber  
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 - 1948 at 6 P.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1942 to August 5 - 1948  
and that I last saw her alive on August 5 - 1948  
Immediate cause of death Cerebral hemorrhage DURATION 2 days  
Due to Chronic hypertensive Cardio 6 yrs  
Vascular disease  
Due to Cerebral hemorrhage 1944  
(Specify side)  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations.....  
Date of op.....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Dawson L. Farber M.D.  
Address Sparrm's Point Md Date signed 8/6/48  
M. D. or other

MARGIN RESERVED FOR BINDING

VS A15 3-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 238

## 1. PLACE OF DEATH:

County BaltimoreCity or town Towson 4, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since October 29, 1947

Hospital, institution, or street address where death occurred:

Eudwood Sanatorium, Towson 4, Md.How long in hospital or institution? Since October 29, 1947

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Balto CityCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3636 Hickory Ave  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Mary PorterMARY PORTER

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Joseph Porter

7. Birth date of

deceased (mo., day, yr.)

September 16, 1874

6. (c) If alive, give age

8. AGE:

731020

Years Months Days

hrs.

min.

9. Birthplace

Kent County, Md.  
(Town, county and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name

Joseph Reed

13. Birthplace

Irreloud

14. Maiden name

Marble Keyes

15. Birthplace

Maryland16. Informant Personal history-Hospital recordsAddress Eudwood Sanatorium, Towson 4, Md.

17. Burial

Burial

Date thereof

Aug 9-1948  
(month) (day) (year)

Cemetery or crematory

Goodlawn

Location

Baltimore Co. Maryland

18. Funeral director

Burpee Funeral Home

Address

3631 Falls Road, Baltimore

19. 8/7

19 8/8

19 8/8

19 8/8

19 8/8

19 8/8

19 8/8

19 8/8

19 8/8

19 8/8

19 8/8

19 8/8

19 8/8

## MEDICAL CERTIFICATION

20. DATE OF DEATH

August 619 48at 7:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 29 19 47 to August 6 19 48and that I last saw him alive on August 6 19 48

Immediate cause of death

Pulmonary tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W A Bridges

M. D.

Address Towson 4, Maryland

Date signed

8-6-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County 3 Hillside Rd.

City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3 Hillside Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

LOUIS PHILLIP RANFT

## 3. (b) Social Security Number

219-07-7800

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife Sophia (Way) Ranft

6.(c) If alive, give age 27 years

7. Birth date of

deceased (mo., day, yr.) October 10, 1920

8. AGE:

27

Years

Months

10

Days

15

If less than one day

hrs.

min.

9. Birthplace BALTIMORE, MARYLAND

(Town, county, and state)

10. Usual occupation

11. Industry or business

Gas &amp; Electric Company

FATHER

12. Name

Charles Ranft

13. Birthplace

Baltimore, Md.

MOTHER

14. Maiden name

Mary G. Daniels

15. Birthplace

Baltimore, Md.

16. Informant

Mrs. Sophia M. Ranft

Address

335 S. Newkirk Street

17. Burial

Date thereof 8/28/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Baltimore National Cemetery

Location

Baltimore, Maryland

18. Funeral director

HENRY SANDER &amp; SONS, INC.

Address

NORTH AVE. &amp; BROADWAY

19.

(Date rec'd by registrar)

19.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1948 at 2.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 25 1946 to Aug. 25 1948

and that I last saw him alive on Aug. 24/48 19

Immediate cause of death

Coronary Thrombosis Acute

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3/

## 1. PLACE OF DEATH:

County BaltimoreCity or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 16 years

Hospital, institution, or street address where death occurred:

6401 Walnut Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6401 Walnut Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Paul Fritz Reincke

## 3. (b) Social Security Number

214-03-4149

4. Sex

Male

5. Color or race

White

B. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Lena Balbier Reincke6. (c) If alive, give age 43 yrs years7. Birth date of deceased (mo., day, yr.) April 18, 1901

8. AGE:

Years

Months

Days

It less than one day

47315

hrs.

min.

9. Birthplace Glasin, Germany

(Town, county, and state)

10. Usual occupation Contractor

11. Industry or business

12. Name Bernhardt Reincke13. Birthplace Glasin, Germany14. Maiden name un known15. Birthplace Germany16. Informant Mr. B. Henry ReinckeAddress 6401 Walnut Ave., Woodlawn, Md.17. Burial Date thereof Aug. 6, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lorraine CemeteryLocation Woodlawn, Md.18. Funeral director Stollis LamonianAddress 4510 Liberty Heights Ave.19. Aug 5 19 48  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 3, 1948 19... at 2:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... 19... 19...  
and that I last saw him alive on 19... 19... 19...

Immediate cause of death

DURATION

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

2470 Washington

M. D. or other

Address 1010 Lehigh Ave Date signed 8-3-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b> County..... <i>Baltimore</i> City or town..... <i>English Counsel</i> <small>(If outside city or town limits, write RURAL and give nearest town)</small> How long in above place of death?..... <i>28 1/2 months</i> Hospital, Institution, or street address where death occurred:..... How long in hospital or institution?.....		<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> <small>(For newborn infants give residence of mother)</small> State..... <i>Maryland</i> County..... <i>Baltimore</i> City or town..... <i>Baltimore Woodlawn</i> <small>(If outside city or town limits, write RURAL and give nearest town)</small> Street No..... <i>26 Summerfield Rd.</i> <small>(If rural, give LOCATION)</small> 2.(a) If veteran, name war.....	
<b>3. (a) FULL NAME</b> <i>Lawrence Wendell Roesch</i>		<b>3. (b) Social Security Number</b> <i>NINE</i>	
<b>4. Sex</b> <i>male</i>	<b>5. Color or race</b> <i>white</i>	<b>6. (a) Single, married, widowed, or divorced</b> <i>married</i>	
<b>6. (b) Name of husband or wife</b> <i>William V. Roesch</i> 6. (c) If alive, give age..... <i>49</i> years			
<b>7. Birth date of</b> deceased (mo., day, yr.) <i>February-13-1894</i>			
<b>8. AGE:</b> Years <i>54</i>	Months <i>6</i>	Days <i>18</i>	If less than one day hrs. .... min. ....
<b>9. Birthplace</b> <i>Baltimore, Md.</i> <small>(Town, county, and state)</small>			
<b>10. Usual occupation</b> <i>Retired machinist</i>			
<b>11. Industry or business</b> <i>Joseph Roesch</i>			
<b>12. Name</b> <i>Joseph Roesch</i>			
<b>13. Birthplace</b> <i>Germany</i>			
<b>14. Maiden name</b> <i>Hanna Schmidt</i>			
<b>15. Birthplace</b> <i>Baltimore</i>			
<b>16. Informant</b> <i>Mrs William Roesch</i> Address..... <i>26 Summerfield Ave Woodlawn</i>			
<b>17. Burial</b> (Burial, cremation, or removal. When?) Date thereof..... <i>9/2/48</i> (month) (day) (year) Cemetery or crematory..... <i>Baltimore</i> Location..... <i>Baltimore</i>			
<b>18. Funeral director</b> <i>William J. Mc</i> Address..... <i>1314 N. Bond St</i> Date rec'd by registrar..... <i>Sept 1 1948</i>			
<b>19. Registrar</b> <i>A. W. H. Hunt</i>			
<b>MEDICAL CERTIFICATION</b>			
<b>20. DATE OF DEATH</b> <i>August-31-1948</i> at <i>12:30</i> M.			
<b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <i>April-6-48</i> to <i>August 31 48</i> and that I last saw him alive on <i>August 30-1948</i>			
<b>Immediate cause of death</b> <i>Cerebral hemorrhage</i>		<b>DURATION</b> <i>2 years</i>	
<b>Due to</b> <i>Hypertension</i>		<b>Due to</b>	
<b>Other conditions</b>			
<small>(Include pregnancy within 3 months of death)</small>			
<b>Major findings of operations</b>			
<b>Autopsy results</b>			
<b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>			
<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b>			
Accident, suicide, or homicide..... Date of.....			
Where did injury occur?..... (City or town) (County) (State)			
Injured at home, farm, industry, public place (where?).....			
Means of injury..... Injured at work?.....			
<b>23. SIGNATURE</b> <i>Walther J. Jomchfeldt M.D.</i> Address..... <i>2708 Hollins Ferry Rd</i> Baltimore, Md. Date signed..... <i>8/31/48</i>			

08165

42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 days

Hospital, institution, or street address where death occurred:

Veterans Administration HospitalHow long in hospital or institution? 23 days2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County a.a.  
 City or town Linthicum Heights  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Hammonds Ferry Road  
 (If rural, give LOCATION)

2.(a) If veteran, name war SAV

## 3. (a) FULL NAME

LORIN D. RONK

## 3. (b) Social Security Number

unknown

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of deceased (mo., day, yr.)

January 16, 1874

## 8. AGE:

Years

Months

Days

If less than one day

74629

hrs.

min.

## 9. Birthplace

Ulster Park Co NY

(Town, county, and state)

## 10. Usual occupation

unemployed

## 11. Industry or business

## FATHER

## 12. Name

unknown

## 13. Birthplace

unknown

## 14. Maiden name

unknown

## 15. Birthplace

unknown

## 16. Informant

Clinical Records Vets Adm Hosp

## Address

Fort Howard Maryland

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

(month) (day) (year)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

19. 8/16 98  
(To be rec'd by registrar)19. 98

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1948 at 12:05P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 231948to August 151948and that I last saw him alive on August 15 1948

## Immediate cause of death

bronchopneumonia

## DURATION

2 weeks

## Due to

## Due to

Other conditions arteriosclerosis, generalyears

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Whom did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

D. R. Price

M. D. or other

Address V. A. Hosp. Fort HowardDate signed 11 Aug 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

## 1. PLACE OF DEATH:

County... Baltimore  
 City or town... Rural near Freeland.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 72 yrs.  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Baltimore  
 City or town... Rural near Freeland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1 mi. East of Freeland.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

George Edward Schlaline.

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Single.

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 14, 1876.8. AGE: Years Months Days If less than one day  
72 0 25 hrs. min.9. Birthplace Freeland, Md. R.D.  
(Town, county, and state)10. Usual occupation Farmer.11. Industry or business Own farm.12. Name John Schlaline.13. Birthplace Germany.14. Maiden name Sophia List15. Birthplace Germany.16. Informant Paul Schaeffer.Address Freeland, Md. R.D.17. Burial Date thereof August 13, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. John's R. C. CemeteryLocation New Freedom, Pa.18. Funeral director Jacob HartensteinAddress New Freedom, Pa.19. Aug 12 1948 Chas. E. ... Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1948 at 7:20 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 2 1948 to Aug 9 1948 and that I last saw him alive on Aug 4 1948Immediate cause of death Acute Bright's disease DURATIONDue to Arterio-sclerosisDue to —Other conditions Large Prostate Gland

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE McDermott MD. M. D. or otherAddress New Freedom Pa. Date signed Aug 9/48

RECEIVED

AUG 18 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

08168

94a

## 1. PLACE OF DEATH

County Baltimore  
 City or town Edgemere (Baltimore 19, Sparrows Pt.)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? about 12 yrs  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Baltimore  
 City or town Edgemere (Baltimore 19, Sparrows Pt.)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3004 Ritchie Ave  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Louise F. (Dymuro) Seckens

## 3. (b) Social Security Number

215-28-4547

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife Andrew J. (Dymuro) Seckens7. Birth date of deceased (mo., day, yr.) April 18, 1896 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 52 Months 3 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Crooksville, Ohio  
(Town, county, and state)10. Usual occupation at home

11. Industry or business

12. Name Mont McDonald13. Birthplace Ohio14. Maiden name Anna Selby15. Birthplace Ohio16. Informant Mont Seckens (Son)Address 3004 Ritchie Ave; Edgemere, Md.17. Burial Date thereof Oct. 7, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oaklawn CemeteryLocation Ed to National Cemetery, Md.18. Funeral director G. Howard EvansAddress 1400 S. Charles St. Balt 39, Md.19. August 5, 1948 D. L. Harber  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Thurs., Aug. 5, 1948 at 7:00 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26, 1948 to August 5, 1948 and that I last saw her alive on August 14, 1948

Immediate cause of death

Coronary occlusion with myocardial infarction and multiple pulmonary infarcts

DURATION

2 mo.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dawson L. Harber MD  
Farmers Point, Md. M. D. or Physician  
 Date signed 8/5/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 9 1948

BUREAU V. S.

Evidence for change of  
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 5X

17 AUG 24 1948

1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 day  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Md.  
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County   
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1243 E. Madison Ave.  
(If rural, give LOCATION)  
2. (a) If veteran, name war SAW

3. (a) FULL NAME

WILLIAM SINGLETON

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife Widower

7. Birth date of deceased (mo., day, yr.) March 1874 B. (c) If alive, give age  years

8. AGE: Years 74 Months 3 Days 7 if less than one day 5 hrs.  min.

9. Birthplace North Carolina  
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name Henry Singleton  
13. Birthplace Unknown

MOTHER 14. Maiden name Emma Dunson  
15. Birthplace North Carolina

16. Informant Clinical Records, Vets. Adm. Hosp.  
Address Fort Howard, Md.

17. Burial Date thereof 8/17/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Norfolk, Virginia  
Location Charles R. Law

18. Funeral director 802 Madison Avenue.  
Address 8-17-48

19. 8-17-48 Registrar W  
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14, 1948 at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 13, 1948 to August 14, 1948  
and that I last saw him alive on August 14, 1948

Immediate cause of death CARDIAC HYPERTROPHY  
AND DILATATION WITH PULMONARY  
EDEMA DURATION Unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations  Date of op.

Autopsy results Substantiated Above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

Where did injury occur?  (City or town)  (County)  (State)

Injured at home, farm, industry, public place (where?)

Manner of injury  injured at work?

23. SIGNATURE Lawrence M. Zell M. D. or other

Address VAH Fort Howard, Md. Date signed 8-16-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltoCity or town Della  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltoCity or town Della  
(If outside city or town limits, write RURAL and give nearest town)Street No. Della Ave  
(If rural, give LOCATION)

2. (a) If veteran, name war.

## 3. (a) FULL NAME

Sarah Alberta Sisk

## 3. (b) Social Security Number

4. Sex F5. Color or race W.

6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband or wife Silas B. Sisk7. Birth date of deceased (mo., day, yr.) May 12 1863

8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Year 85 Month 3 Days \_\_\_\_\_ It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Livermore, Anne Arundel Co  
(Town, county, and state)10. Usual occupation none11. Industry or business none12. Name Frank Phelps13. Birthplace unknown14. Maiden name unknown15. Birthplace unknown16. Informant Silas Sisk

Address \_\_\_\_\_

17. Burial Date thereof 8-15-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. MichaelLocation Howard County18. Funeral director F. C. HigginbottomAddress Ellicott City19. 8-13-48 VE. Harry  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 48 at 4 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death \_\_\_\_\_

## DURATION

acute cardiac failure

Due to \_\_\_\_\_

Due to cardiovascular diseaseOther conditions sinusitis

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Geo. M. Kieffer Sept 11 48  
M. D. or other \_\_\_\_\_Address 1010 Leeds Ave Date signed Aug 22 48

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

RECEIVED

RECEIVED  
AUG 14 1948  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

### 1. PLACE OF DEATH:

County Baltimore  
City or town Kingsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 22 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Kingsville, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Jerusalem Rd.  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Hatter Maybelle Smith

### 3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife David M. Smith  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) Aug. 19th, 1881  
8. AGE: Year 67 Months \_\_\_\_\_ Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Montgomery County, Md.  
(Town, county, and state)  
10. Usual occupation at home  
11. Industry or business  
12. Name Daniel Tetlow  
13. Birthplace Carroll County, Md.  
14. Maiden name Sallie Guyton  
15. Birthplace Frederick County, Md.

16. Informant Mr. David M. Smith  
Address Jerusalem Rd., Kingsville, Md.  
17. burial Date thereof 8/26/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory St. Michaels  
Location Perry Hall, Md.  
18. Funeral director Lassahn Funeral Home  
Address 7401 Belair Rd.  
19. (Date rec'd by registrar) \_\_\_\_\_ Registrar \_\_\_\_\_ Address \_\_\_\_\_ Date signed \_\_\_\_\_

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1948 at 7:50 A M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 2 1948 to Aug 23 1948  
and that I last saw him alive on Aug 23 1948  
Immediate cause of death coronary occlusion  
DURATION 3 weeks  
Due to Arteriosclerosis 10 yrs  
Due to Diabetes Mellitus 10 yrs  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
When did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Fred O. Hodson M.D. M. D. of other \_\_\_\_\_  
Address Edgewood Rd Date signed 8-23-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

SEP 3 1948

BUREAU V. 3.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Baltimore

City or town Stoneleigh  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

How long in hospital or institution? .....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Stoneleigh  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6803 York Road  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

### 3. (a) FULL NAME

John Smith

### 3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	---

6.(b) Name of ~~husband~~ or wife Lida Satterfield

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 12th 1872

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>11</u>	<u>15</u>	..... hrs. .... min.

9. Birthplace Baltimore, Md.  
(Town, county, and state)

10. Usual occupation Insurance Business

11. Industry or business

12. Name Christian Smith

13. Birthplace Germany

14. Maiden name Not Known

15. Birthplace Germany

16. Informant Mrs. Lida Smith

Address 6803 York Road - 12

17. Burial Date thereof 8/30/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Baltimore

Location Baltimore, Md.

18. Funeral director E. I. Fanning & Son

Address 1938 R. Lafayette Ave. 13

19. 8/30 19 48 A. W. Hedrick  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28th 19 48 at 9:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 27 19 48 to Aug. 28 19 48 and that I last saw him alive on Aug. 27 19 48

Immediate cause of death Cerebrovascular accident

Due to hypertensive C-V disease

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Carl Mason M. D. or M. D. Balto.

Address 1533 E. Calverline Date signed Aug. 28, 48

MARGIN RESERVED FOR BINDING

I

VS/A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

08173

44

### 1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 101 Days  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Md.  
How long in hospital or institution? 101 Days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County   
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4407 Forest View Ave.  
(If rural, give LOCATION)  
2. (a) If veteran, name war WW-2

### 3. (a) FULL NAME

CHRISTOPHER SORTINO

### 3. (b) Social Security Number

Unknown 215-18-3783

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of deceased's wife Rose Sortino  
6. (c) If alive, give age 37 years  
7. Birth date of deceased (mo., day, yr.) 1-15-09  
8. AGE: Years 39 Months 7 Days 5 It less than one day  hrs.  min.

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 19 48 at 7:10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11, 19 48 to August 20, 19 48 and that I last saw him alive on August 20, 19 48

Immediate cause of death MYELO-ENCEPHALITIS, ACUTE DURATION 3 MOS.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations  Date of op.

Autopsy results Substantiated Above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

Where did injury occur?  (City or town)  (County)  (State)

Injured at home, farm, industry, public place (where?)

Manner of injury  Injured at work?

23. SIGNATURE Paul Padgett M.D. or other

Address VAH, Ft. Howard, Md. Date signed 8-20-48

9. Birthplace Italy (Town, county, and state)  
10. Usual occupation Barber  
11. Industry or business   
12. Name Vinson Sortino  
13. Birthplace Italy  
14. Maiden name Filomena Cesta  
15. Birthplace Italy  
16. Informant Clinical Records, Vets. Adm. Hosp.  
Fort Howard, Maryland  
Address   
17. Burial Date thereof 8/24/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Holy Redeemer Cemetery  
Baltimore, Md.  
Location   
18. Funeral director Wm. Cook, Inc.  
Baltimore, Md.  
Address   
19. 8/21 19 48 J. H. Hedrick  
(Date rec'd by registrar) (month) (day) (year) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

O.K. JLP

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08174

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hood Convalescent Home, 5313 Edmondson Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A.City or town Wardour, Annapolis  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Margaret Ann Stallings

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife John L. Stallings

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) April 23, 1860

## 8. AGE:

Years

Months

Days

If less than one day

88316

hrs.

min.

9. Birthplace Annapolis, Md.  
(Town, county, and state)10. Usual occupation None

## 11. Industry or business

12. Name James Wells13. Birthplace Annapolis, Md.14. Maiden name Mary Elizabeth Mitchell15. Birthplace Annapolis, Md.16. Informant Mrs. Alexander ProxkeyAddress Wardour, Annapolis, Md.17. Burial Date thereof August 11, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Margaret's CemeteryLocation Anne Arundel County, Md.18. Funeral director E. Miller LamoreauAddress 4510 Liberty Heights Ave.19. 8-9 19 48  
(Date rec'd by registrar)Registrar W E Harry

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 19 48 at 10 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 19 48 to Aug 9 19 48 and that I last saw him/her alive on Aug 9 19 48

Immediate cause of death

Pericardial Thrombosis

DURATION

3 daysDue to Arterio Sclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE James E. Bowen M. D. or otherAddress 715 Frederick Ave. Catonsville, Md. Date signed 8-9

**RECEIVED**

AUG 11 1948

**BUREAU V. S.**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

08175

XX

## 1. PLACE OF DEATH:

County Balto.City or town Bengies  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
Hughes Rd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 264 S. Bouldin St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

IGNATIUS T. STEFANSKI

## 3. (b) Social Security Number

no

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife Rose N. Stefanski (nee Krupin-

ski)

7. Birth date of deceased (mo., day, yr.) July 12, 1884  
6. (c) If alive, give age years

## 8. AGE:

Years 64Months 0Days 24

If less than one day

hrs. min.

9. Birthplace Germany  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

Own Business

## FATHER

12. Name Thomas Stefanski13. Birthplace Germany

## MOTHER

14. Maiden name Unknown15. Birthplace "16. Informant Mrs. Rose M. StefanskiAddress 264 S. Bouldin St.17. Burial 8/9/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Stanislaus's Cem.Location Balto., Md.WM. J. TICKNER & SONS18. Funeral director Balto., Md.

Address

19. 8/7 x 8 RW Hedrick  
(Date rec'd by registrar) 19 8/7/48 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6, 19 48, at 10:00a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/16/48 - seen only one time - 19and that I last saw h. am alive on 7/16/48 19

Immediate cause of death

DURATION

Pulmonary Tuberculosis - several years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 11 E. Chase St. Date signed 8/7/48

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

### 1. PLACE OF DEATH:

County Baltimore

City or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

Bertha F Thomas

### 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Franklin C Thomas

7. Birth date of deceased (mo., day, yr.)

June 29 1877

6. (c) If alive, give age ..... years

8. AGE:

Years

Months

Days

If less than one day

71

2

11

hrs.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

FATHER  
MOTHER

12. Name George W. Dovell

13. Birthplace

Va

14. Maiden name

Jennie E Hefner

15. Birthplace

Va

16. Informant

Mrs. Lola Louiarino

Address 229 Detroit Ave

17.

Burial

Date thereof Sept 1 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Druid Ridge

Location

Pikesville, Md

18. Funeral director

Ullrich Funeral Home

Address

2008 Orleans St

19.

Aug 31 19 48

A. W. Hedrick

(Date received by registrar)

Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

B.H.

City or town

Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No.

229 Detroit Ave

(If rural, give LOCATION)

2. (a) If veteran, name war

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948 19. 530 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July 28 19 48 to August 29 19 48  
and that I last saw him alive on August 28 19 48

Immediate cause of death

Generalized metastatic carcinoma

DURATION

1 yr.

Due to metastatic carcinoma

3 yrs

Due to heart

about

Other conditions Hypertension

3 yrs

arteriosclerosis  
(Include pregnancy within 3 months of death)

Major findings of operations

no operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

516 Cathlamet

Date signed

8-30-48

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and correctly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Owings Mills  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 yrs. 2 mos. 28 days  
 Hospital, institution, or street address where death occurred:  
Rosewood State Training School  
 How long in hospital or institution? 4 yrs. 2 mos. 28 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother) Montgomery  
 State Maryland County Baltimore  
 City or town Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 701 Eastway  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Verlinda Lee Thompson

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife.....  
 7. Birth date of deceased (mo., day, yr.) May 22 - 1938 6.(c) If alive, give age..... years  
 8. AGE: Years 10 Months 3 Days 9 If less than one day..... hrs. .... min.

9. Birthplace Takoma Park, Maryland  
 (Town, county, and state)  
 10. Usual occupation None  
 11. Industry or business.....

MOTHER FATHER  
 12. Name Joseph Stover Thompson  
 13. Birthplace Washington, D.C.  
 14. Maiden name Virginia Maupin  
 15. Birthplace Salisbury, N.C.

16. Informant Hospital records  
 Address Rosewood, Owings Mills, Md.  
 17. Burial Date thereof Sept 27 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory 7th Runnaker Cemetery  
 Location Prince Georges Co Md

18. Funeral director Warner E. Pumphrey Inc.  
 Address 8434 Georgia Ave. Silver Spring Md.  
 19. 8/31 19 48 Dr E E Nichols  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 19 48 at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30 19 48, to 19.....  
 and that I last saw her alive on August 30 19 48.

Immediate cause of death Diarrhoea and enteritis DURATION 1 day

Due to.....  
 Due to.....

Other conditions Congenital cerebral lesion with spastic paraplegia 10 yrs. plus  
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE Viola Barrett Johns, M.D. M. D. or other  
 Address Rosewood State Tr School Date signed 8/30/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County BaltoCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Charles N. Thumel

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Alma Smith7. Birth date of deceased (mo., day, yr.) Oct. 28, 1878

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 69 Months 9 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Balto. Md.  
(Town, county, and state)10. Usual occupation Restaurant Owner (Retired)

11. Industry or business

12. Name Charles N. Thumel13. Birthplace W. Va.14. Maiden name Anna Beckman15. Birthplace Balto. Md.16. Informant Mrs. Alma ThumelAddress Baltimore, Md.17. Burial Date thereof 8/9/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Immaculate ConceptionLocation Stowson, Md.18. Funeral director E. J. Ganning, Inc.Address 938 E. Lafayette Ave19. 8/7 19. 48 J. W. Hedrick  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 19. 48 10:10 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19. 48 to Aug 5 19. 48and that I last saw him alive on August 5 19. 48

Immediate cause of death

Right heart failure  
(cor pulmonale)Due to Emphysema, pulmonary,  
with bronchiectasis

Due to \_\_\_\_\_

Other conditions Arteriosclerosis, general

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Harry Z. Kneifel

M. D. or other

Address 1101 St. Paul St. Date signed Aug 7, 48

MARGIN RESERVED FOR BINDING

V. S. No. 7

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

208173

## 1. PLACE OF DEATH

County BaltimoreRegistration Dist. No. 31Village or City W. Wood LaneNo. 6802 Windsor Mill Rd. St. \_\_\_\_\_ Ward \_\_\_\_\_

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. How long in U.S. If of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

2. FULL NAME Nora E. Turner

If U. S. Veteran, specify WAR \_\_\_\_\_

(a) Residence: No. 808 N. Augusta Ave.

St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

If nonresident give city or town and State \_\_\_\_\_

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED,  
OR DIVORCED (write the word)Widow

5a. If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofLate Franklin P. Turner6. DATE OF BIRTH (month, day, and year) Feb. 17, 1870.

7. AGE

Years

78

Months

5

Days

23

If LESS than

1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.

OCCUPATION

8. Trade, profession, or particular  
kind of work done, as SPINNER,  
SAWYER, BOOKKEEPER, etc.None9. Industry or business in which  
work was done, as SILK MILL,  
SAW MILL, BANK, etc.10. Date deceased last worked at  
this occupation (month and  
year) \_\_\_\_\_11. Total time (years)  
spent in this  
occupation \_\_\_\_\_

12. BIRTHPLACE (city or town)

(State or country)

Md.

FATHER

13. NAME

James P. Watts

14. BIRTHPLACE (city or town)

(State or country)

Md.

MOTHER

15. MAIDEN NAME

Sarah Phelps

16. BIRTHPLACE (city or town)

(State or country)

Md.

17. INFORMANT

(Address)

Mrs. Robert W. Harper  
808 N. Augusta Ave.

18. BURIAL, CREMATION, OR REMOVAL

Place

Burial, Druid Ridge Aug. 13/48

19. UNDERTAKER

(Address)

Harry A. White  
4101 Edmondson Ave.

20. FILED

8/13/48

19

48

19

48

19

48

19

48

19

48

19

48

19

48

19

48

19

48

19

48

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

Aug. 10/48.

(Month)

(Day)

193

(Year)

22.

I HEREBY CERTIFY, That I attended deceased from

May 25, 1948, to Aug. 10, 1948I last saw her alive on August 9, 1948; death is saidto have occurred on the date stated above, at 11.30 A.M.The PRINCIPAL CAUSE OF DEATH and related causes of importance  
were as follows:

Date of onset

Cardiac failure

Other Contributory Causes of Importance:

arteriosclerotic cardiovascular  
renal disease1 yr

Name of operation \_\_\_\_\_

Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of Injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did Injury occur? \_\_\_\_\_

(Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?

If so, specify \_\_\_\_\_

(Signed) \_\_\_\_\_

M. D.

(Address) \_\_\_\_\_

3030 Edmondson Avenue8/12/48



# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

---



---



---



---



---

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08180

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mount Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 0 yrs., 8 mos., 21 days  
 Hospital, institution, or street address where death occurred: Mt. Wilson  
Branch, Md. T. B. Sanatorium  
 How long in hospital or institution? 0 yrs., 8 mos., 21 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Mont. Co.  
 City or town Rockville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R.F.D. Westmore  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war ✓

## 3. (a) FULL NAME

William M. Turner

## 3. (b) Social Security Number

579-10-1142

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mrs. Mary Turner

7. Birth date of deceased (mo., day, yr.) April 30, 1921  
 6. (c) If alive, give age 21 years

8. AGE: Years 27 Months 3 Days 6 If less than one day  
 .... hrs. .... min.

9. Birthplace Paytes, Virginia  
(Town, county, and state)10. Usual occupation Carpenter

11. Industry or business

12. Name James Turner13. Birthplace Paytes, Virginia14. Maiden name Lilly Baxter15. Birthplace Paytes, Virginia16. Informant Wm. M. TurnerAddress R.F.D. Westmore, Rockville, Md.

17. Burial Date thereof Aug. 9, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National Cem.Location Arlington, Virginia18. Funeral director W. R. PumphreyAddress Bethesda, Maryland

19. Aug. 5, 1948  
 (Date rec'd by registrar) Hele R. Mayer  
 Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH August 5, 1948, at 6:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
November 15, 1947, to August 5, 1948.  
 and that I last saw him alive on August 5, 1948.

Immediate cause of death Pulmonary Tuberculosis  
 DURATION 7 yrs.

Due to Tubercle Bacilli

Due to

Other conditions Tuberculous Enteritis 1 Yr.

(Include pregnancy within 3 months of death)

Major findings of operations No operation.

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. L. Siegel M.D. M. D. or otherAddress Mt. Wilson, Md. Date signed 8/5/48

RECEIVED

AUG 11 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

## 1. PLACE OF DEATH:

County Towson  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

58

Years

Months

4

Days

6

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

17. Burial

18. Funeral director

19. August 12, 1948

20. August 12, 1948

21. August 12, 1948

22. August 12, 1948

23. August 12, 1948

24. August 12, 1948

25. August 12, 1948

26. August 12, 1948

27. August 12, 1948

28. August 12, 1948

29. August 12, 1948

30. August 12, 1948

31. August 12, 1948

32. August 12, 1948

33. August 12, 1948

34. August 12, 1948

35. August 12, 1948

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TowsonCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 426 Virginia Ave.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 10, 1948 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him None 19... to... 19...Immediate cause of death Fracture of neck in fall, SuicideDue to mental depression from poor healthOther conditions 6 mo.Major findings of operations 6 mo.Autopsy results 6 mo.

PHYSICIAN: Please underline the cause to which death should be charged statistically:

22. VIOLENCE: If death was due to external causes, in the following:

Accident, suicide, or homicide Suicide Date of 8/10/48Where did injury occur? Towson Md (City or town) Baltimore (State)Injured at home, farm, industry, public place (where?) Towson MdMeans of injury Jumped off dam Injured at work? No23. SIGNATURE Bollin C. Hudson MD DMEAddress Towson Md Date signed 8/10/48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 years, 9 months, 22 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 2 years, 9 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Prince George  
 City or town Hyattsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4523 Buchanan Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Daisy Elenore Ward

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed  
 6. (b) Name of husband or wife George Richard Ward  
 7. Birth date of deceased (mo., day, yr.) August 31, 1881  
 6. (c) If alive, give age ..... years  
 8. AGE: Years 66 Months 11 Days 30 If less than one day hrs. min.

9. Birthplace Montgomery County, Maryland  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Home  
 12. Name Oliver Merchant Rickett  
 13. Birthplace Montgomery County, Maryland  
 14. Maiden name Sarah Elizabeth Johnson  
 15. Birthplace Alexandria, Virginia

16. Informant Hospital records  
 Address Catonsville-28, Maryland  
 17. Funeral Date thereof 9/8/48  
 (Burial, cremation, or removal. Which?) month (day) (year)  
 Cemetery or crematory Arlington  
 Location Washington, D.C.  
 18. Funeral director W. J. Chambers  
 Address Washington  
 19. Aug 30, 48 A. W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 19 48 at 3:45 PM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19..... to 19.....  
 and that I last saw him alive on 19.....  
 Immediate cause of death

Acute Cardiac failure  
 Due to.....  
Cardiovascular renal  
 Due to.....  
 Other conditions disease  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, pub'c place (where?)  
 Means of injury Injured at work?

23. SIGNATURE Geo. M. Kieffer Deputy  
 M. D. or other as  
 Address 1010 Leidsen Date signed 8-30-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County BaltimoreCity or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)State Md County BaltimoreCity or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1724 Bayard Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

John J. Weber

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Mary C. Hartline

7. Birth date of deceased (mo., day, yr.)

Jan. 27, 1885

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

63615

hrs.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual occupation

Foreman

11. Industry or business

MOTHER FATHER

12. Name

M. Weber

13. Birthplace

Baltimore

14. Maiden name

Anna Bosman

15. Birthplace

Baltimore

16. Informant

Mrs. Eleanore A. Weaver

Address

1724 Bayard Ave.

17.

Burial

Date thereof

8/14/48

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Oak Lawn

Location

7225 Eastern Ave.

18. Funeral director

Clarence F. Hoffmann

Address

1639 Broadway.

19.

(Date rec'd by registrar)

August 13 48O. W. Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 19 48 at 7 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June19 48to Aug. 1119 48and that I last saw him alive on August 11 19 48

Immediate cause of death

Coronary Thrombosis

DURATION

Due to

Arterio sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George Zeller M.D.

M. D. or other

Address 2739 Eastern Ave.Date signed 8/13/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County... BaltimoreCity or town... Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?... 40 days

Hospital, institution, or street address where death occurred:

Veterans Administration HospitalHow long in hospital or institution?... 40 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County.....City or town... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 429 S. Hanover Street

(If rural, give LOCATION)

2.(a) If veteran, name war... WWII ✓

## 3. (a) FULL NAME

WILLIAM J. WEIGAND

## 3. (b) Social Security Number

Unknown4. Sex... Male5. Color or race... White6.(a) Single, married, widowed, or divorced... Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)... December 28, 19018. AGE: Years... 46 Months... 7 Days... 15 It less than one day... hrs. .... min.9. Birthplace... Baltimore, Md.  
(Town, county, and state)10. Usual occupation... Odd jobs

11. Industry or business

12. Name... ?13. Birthplace... ?14. Maiden name... ?15. Birthplace... ?16. Informant... Clinical Records, Vet. A. n. Hosp.Address... Fort Howard, Md.17. Burial Date thereof... 8/17/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Baltimore National CemeteryLocation... Baltimore, Md.18. Funeral director... Howard Blight Funeral HomeAddress... 6009 Harford Rd. Balto. Md.19. (Date rec'd by registrar) 19... 8/13/48 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... August 13 1948 at... 7:05 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July 4 1948 to August 13 1948and that I last saw him alive on August 13 1948Immediate cause of death... TOXEMIA

DURATION

UnknownDue to PARTIAL INTESTINAL OBSTRUCTION UnknownDue to ADENOCARCINOMA OF INTESTINE Unknown

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Howard BlightH.C. MANAUGH, M.D., CHIEF, PROFESSIONAL SERV.Address... VAH, Ft. Howard, Md. Date signed... 8/13/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Approximately 4 Hrs.

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, MarylandHow long in hospital or institution? Approximately 4 Hrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty BaltimoreCity or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)Street No. Dogwood Road  
(If rural, give LOCATION)2. (a) If veteran, name war WW I

## 3. (a) FULL NAME

W.  
HOWARD/WHITMORE

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.) 10-16-88

## 8. AGE:

Years

Months

Days

If less than one day

59103

hrs.

min.

9. Birthplace Hillsdale, Md.

(Town, county, and state)

10. Usual occupation Laborer

## 11. Industry or business

FATHER  
MOTHER12. Name John Whitmore13. Birthplace Frederick County, Md.14. Maiden name Alice Springer15. Birthplace Frederick County, Md.16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial

(Burial, cremation, or removal, Which?)

Date thereof Aug 23, 1948  
(Month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland16. Funeral director G. Howard StrongAddress Baltimore, Md.

## 19.

(Date read by registrar)

19.

48

R.W. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1948 at 7:55 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19, 1948 to August 19, 1948 and that I last saw him alive on August 19, 1948

Immediate cause of death

Hemorrhage from esophageal varices

DURATION

1 dayDue to Cirrhosis of liver10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Manner of injury \_\_\_\_\_ injured at work?

## 23. SIGNATURE

V.F. SCULLIO, M.D.

M. D. or other

Address VAH, FORT HOWARD, MD. Date signed 8-20-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 08186 32

## 1. PLACE OF DEATH

County BaltimoreCity or town Randallstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Walter S. Kiderman

7. Birth date of deceased (mo., day, yr.)

Feb. 21 1864

8. AGE:

84 Years 6 Months 7 Days If less than one day

9. Birthplace

Granite, Balto Co. Md.  
(Town, county, and state)

10. Usual occupation

House

11. Industry or business

Refuse Caddy

12. Name

Ellicott City, Md.

13. Birthplace

Mary Spiebach

14. Maiden name

Ms. Grace Stierloff

15. Birthplace

Baltimore, Md.

16. Informant

Burial

17. (Burial, cremation, or removal to)

Aug. 31 1948

18. Cemetery or crematory

St. Charles Cemetery

19. Location

Randallstown, Md.

20. Funeral director

B. Miller Layman

21. Address

4510 Liberty Heights Ave

22. 8-30-48

1948

23. Dr. E. E. Nichols

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Randallstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. Liberty Road  
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 28 1948 at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 27 1948 to Aug 28 1948and that I last saw him alive on Aug 28 1948

Immediate cause of death

Chronic myocarditisDue to arterio sclerosisDue to Arterial hypertensionOther conditions Senility

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. E. Nichols M. D. or otherAddress Pikesville Date signed 9/30/48

RECEIVED

AUG 31 1948

BUREAU V. S.

Evidence for change of  
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 117 SEP 15 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

County Baltimore  
City or town Middlebrook, Balto. 21  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles A. Wilburn

3. (b) Social Security Number

217-07-4282

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Nora E. Wilburn

7. Birth date of

deceased (mo., day, yr.)

October 26, 1918

8. AGE:

Years

Months

Days

If less than one day

39 29

9

29

hrs.

min.

9. Birthplace

Barton Md.

(Town, county, and state)

10. Usual occupation

Balto. Transit Co.

11. Industry or business

Abraham Wilburn

FATHER

12. Name

Md.

13. Birthplace

MOTHER

14. Maiden name

Rose---

Md.

15. Birthplace

16. Informant

Mrs. Nora E. Wilburn

Address

1211 Wohler Way, O'Donnell Heights

17.

Burial

Date thereof

Aug. 28/48

(Burial, cremation, or removal. Which?)

Cemetery or crematory

U.S. National Cem.

Location

Balto. Md.

18. Funeral director

Address

2024 Orleans St.

19.

Aug 26 1948

19

48

Theresa M. Wiley

Registrar

Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1211 Wohler Way (O'Donnell Heights)  
(If rural, give LOCATION)

2. (a) If veteran, name war

#24-

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25, 1948 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Aug 25, 1948

Immediate cause of death

Stroke from pt +

Stroke from pt +

Stroke from pt +

Stroke from pt +

Stroke from pt +

Stroke from pt +

Stroke from pt +

Stroke from pt +

Stroke from pt +

Stroke from pt +

Stroke from pt +

Stroke from pt +

Stroke from pt +





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age in especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 39

## 1. PLACE OF DEATH:

County Baltimore County  
 City or town RURAL  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Not in hospital. Rural (Baldwin P.O.)

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County Baltimore County

City or town RURAL (Baldwin P.O.)  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

FLORENCEWILLIS

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Widowed.

## 6. (b) Name of husband or wife

— Chas. Willis

## T. Birth date of

deceased (mo., day, yr.)

April 10, 1855

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

93417

hrs.

min.

## 9. Birthplace

Baltimore County

(Town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

None

## FATHER

## 12. Name

Joseph Mayers

## 13. Birthplace

Spain

## MOTHER

## 14. Maiden name

Angelina Mayers

## 15. Birthplace

U.S.A. (place unknown)

## 16. Informant

Mrs. Marguerite Levere (niece)

## Address

Baldwin, Md.

## 17. Burial

(Burial, cremation, or removal, which?)

## Date thereof

8-28-48

## Cemetery or crematory

mt Zion A.M.E.

## Location

Long Green Road

## 19. Funeral director

J. Scott Brooks

## Address

Sparks, Md.

## 19.

(Date rec'd by registrar)

8/27/48Anna Price

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 19 48 at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 26 19 48 to August 27 19 48and that I last saw her alive on Aug. 26 19 48

Immediate cause of death

Bronchopneumonia  
Arteriosclerotic cardio-  
vascular disease.

## DURATION

Due to

Other conditions Malunited fracture  
of neck of right femur  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Greg. G. Merrill MD

M. D. or other

Address

Baldwin, Md.Date signed 8/27/48

RECEIVED

AUG 31 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 38

## 1. PLACE OF DEATH:

County BaltimoreCity or town Towson L., Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since July 8, 1948Hospital, institution, or street address where death occurred:  
Eudowood Sanatorium, Towson L., MarylandHow long in hospital or institution? Since July 8, 1948

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balto CityCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 527 S. Caroline  
(If rural, give LOCATION)2.(a) If veteran, name war ✓

## 3.(a) FULL NAME

Dorothy L. Wisniewski (Wisniewski)

## 3.(b) Social Security Number

218-07-56034. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Mar6.(b) Name of husband or wife Walter Wisniewski6.(c) If alive, give age 35 years7. Birth date of deceased (mo., day, yr.) November 16, 19128. AGE: Years 35 Months 8 Days 25 If less than one day hrs. min.9. Birthplace Virginia Manassas  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Charles Crapill12. Name Charles Crapill13. Birthplace Virginia14. Maiden name Mary Conks15. Birthplace Virginia16. Informant Personal history- hospital recordsAddress Eudowood Sanatorium, Towson L., Maryland17. Removal 8/14/48  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)Cemetery or crematory ManassasLocation Manassas, Va.18. Funeral director William J. Tickner & SonsAddress North & Pa. Aves.19. 8/12 48 SW Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 19 48 at 10.00 A. M21. CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 19 48 to Aug 11 19 48and that I last saw her alive on Aug 10 19 48Immediate cause of death Pulmonary tuberculosisDURATION Since Dec 1947Due to Since Dec 1947Due to Since Dec 1947Other conditions Since Dec 1947

(Include pregnancy within 3 months of death)

Major findings of operations Since Dec 1947Date of op. Since Dec 1947Autopsy results Since Dec 1947

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Since Dec 1947 Date of Since Dec 1947

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Since Dec 1947Means of injury Since Dec 1947 Injured at work? Since Dec 194723. SIGNATURE W.A. Bridges M. D. or other Since Dec 1947Address Towson L., Maryland Date signed Since Dec 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

193

08190

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

## 1. PLACE OF DEATH:

County BALTIMORE  
 City or town BAY SHORE PARK - SPARROWS Pt. Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

BAY SHORE AMUSEMENT PARK

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State NEW JERSEY CountyCity or town CLYTESVILLE  
(If outside city or town limits, write RURAL and give nearest town)Street No. 130 WASHINGTON AVE.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

ROBERT E. WITHNELL

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 11, 1928

8. AGE: Years 19 Months 8 Days 5 It less than one day  
 hrs. min.

9. Birthplace ENGLAND  
(Town, county, and state)10. Usual occupation MACHINE OPERATOR11. Industry or business BAY SHORE AMUSEMENT PARK12. Name HAROLD WITHNELL13. Birthplace ENGLAND14. Maiden name MARY DOVIES15. Birthplace ENGLAND16. Informant HAROLD WITHNELLAddress 130 WASHINGTON AVE.  
CLYTESVILLE N.J.17. BURIAL Date thereof AUG. 24 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory GROVE CHURCH CEMETERYLocation NORTH BERGEN N.J.18. Funeral director Roland L. FisherAddress 2112 DUNDALK AVE.  
DUNDALK 22 MD.19. Aug. 17 19 48 William M. Kelly Jr.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 19 48 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death Electrocuted

DURATION

Due to Contact c. Electric Drill

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident 8/16/48

Accident, suicide, or homicide Date of

Where did injury occur? New Bay Shore Park - Bayshore  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Side of homeMeans of injury Contact c. Electric Drill Injured at work? Yes23. SIGNATURE W. M. Kelly Jr.Address 2112 DUNDALK AVE.Date signed 8/17/48

RECEIVED

AUG 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

08191

30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (if outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 18 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County   
 City or town Baltimore  
 (if outside city or town limits, write RURAL and give nearest town)  
 Street No. 2437 Reisterstown Road  
 (if rural, give LOCATION)  
 2. (a) If veteran, name war  ✓

## 3. (a) FULL NAME

Anne M. Wurtzer

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Lee J. Wurtzer  
 6. (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) July 6, 1889  
 8. AGE: Years 59 Months 1 Days 12 If less than one day  hrs.  min.

9. Birthplace Baltimore, Md.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Domestic

MOTHER FATHER  
 12. Name Joseph Lowe  
 13. Birthplace Maryland  
 14. Maiden name Mary Lauman  
 15. Birthplace Maryland

16. Informant Hospital records  
 Address Catonsville 28, Maryland

17. Burial 8/21/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery XXXXXX New Cathedral  
 Location Baltimore Md.

18. Funeral director WM. J. TICKNER & SONS INC.  
 Address North & Pa. Aves. Balto. 17, Md.

19. 8-19-48 19 48 Isadore Tuerk  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 19 48, at 6:05 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31 19 48, to August 18 19 48.

and that I last saw her alive on August 18 19 48.

Immediate cause of death Cerebral thrombosis DURATION 15 min.

Cerebral sclerosis Isidif

Chronic mitral valvular Isidif

heart disease Isidif

Chronic glomerular "

nephritis - 3<sup>rd</sup> stage

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury  Injured at work?

Isadore Tuerk, M.D.

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other

Address Catonsville 28, Md. Date signed 8/19/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

08192

44

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 133 Days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp., Fort Howard, Maryland  
 How long in hospital or institution? 133 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County AA  
 City or town Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 11 College Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WW-I

## 3. (a) FULL NAME

BERNARD F. WYATT

## 3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Divorced

6.(b) Name of husband or wife Divorced7. Birth date of deceased (mo., day, yr.) 7-6-92

8. AGE: Years 56 Months 1 Days 10 It less than one day hrs. min.

9. Birthplace Annapolis, Md.  
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Edward Wyatt13. Birthplace Virginia14. Maiden name Mary Manderville15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.  
Fort Howard, Md.  
 Address

17. Burial Date thereof 8/19/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery  
Baltimore, Maryland  
 Location

18. Funeral director Charles R. Law  
802 Madison Ave., Balto., Md.  
 Address

19. 8-19 48 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 16, 1948 at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 5, 1948 to August 16, 1948  
 and that I last saw him alive on August 16, 1948

Immediate cause of death Pulmonary tuberculosis with hemorrhage.

## DURATION

18 Mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Padget

PAUL PADGET, M.D. Act. Chief of Ser.

Address VAH, Ft. Howard, Md. Date signed 8-17-48

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH

County Baltimore  
City or town Hydes  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 5 mo.  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)  
State Maryland County Baltimore  
City or town Hydes  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Patterson Rd.  
(If rural, give LOCATION)  
2.(a) If veteran, name war No

3. (a) FULL NAME

George Elmer Zepp

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (A) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary Matilda Betty

7. Birth date of deceased (mo., day, yr.)

May 3, 1847 1897

8. AGE:

Years 51 Months 2 Days 29 If less than one day  
\* hrs. min.

9. Birthplace

Baltimore, Md.  
(Town, county, and state)

10. Usual occupation

Photographic plant store owner

11. Industry or business

Photographic business

FATHER

12. Name

Simon Zepp

13. Birthplace

Westminster, Md.

MOTHER

14. Maiden name

Katherine Behm

15. Birthplace

Baltimore, Md.

16. Informant

Mrs. Mary Matilda Zepp (Wife)

Address

Hydes, Md.

17. Funeral

Funeral

(Burial, cremation, or removal. Which)

Date thereof 8/5/48

Cemetery or crematory

London Park

Location

Baltimore, Md.

18. Funeral director

William C. Zepp

Address

1217 H. St.

19.

Aug 2 19 48 a. w. Hedrick

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 2 19 48 845 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him None 19

Immediate cause of death

Gunshot thru mouth and head

DURATION

sudden 8/2/48

Due to Mental depression from illness 5 mo.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 8/2/48

Where did it occur? Hydes Baltimore Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? no

23. SIGNATURE

Bollin C. Hudson MD DHE

M. D. or other

Address Towson 4 Md. Date signed 8/2/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08194

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

Catons Nursing HomeHow long in hospital or institution? 4 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County HowardCity or town Highland  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

W. Linwood Zimmerman

## 3. (b) Social Security Number

4. Sex M 5. Color or race W. 6. (a) Single, married, widowed, or divorced MarriedB. (b) Name of husband or wife Mary Della Zimmerman7. Birth date of deceased (mo., day, yr.) June 22 1880 B. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 68 Months 2 Days 11 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Fredrick Co. Ind.  
(Town, county, and state)10. Usual occupation Retired Farmer11. Industry or business Farmer12. Name Jackman Zimmerman13. Birthplace Fredrick14. Maiden name Annie C. Baer15. Birthplace Fredrick Ind.16. Informant Mrs Mary D. ZimmermanAddress Highland Ind.17. Burial Forest Oak Date thereof 9-2-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Forest OakLocation Garthersburg Ind.18. Funeral director Dr. Wito DonaldsonAddress Laurel Ind.19. 9-1-48 J.E. Herrey

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1948 at 9:00 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22 1948 to August 31 1948and that I last saw him alive on August 30 1948Immediate cause of death Myocardial infarctionDURATION 2 moDue to Chs. Cardio-renal-vascular Disease

15 mo (?)

Due to \_\_\_\_\_

Other conditions Hemiplegia

27 mo.

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town) (County) (State)

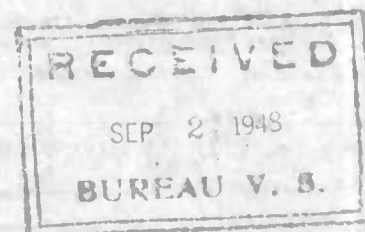
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William K. Gallapoulos

M. D. or other \_\_\_\_\_

Address 62097 Frederick Rd. Balt 28Date signed 8-31-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 08195 30

## 1. PLACE OF DEATH:

County Baltimore CoCity or town Catonville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

Catonville Convalescent HomeHow long in hospital or institution? 4 years

## 3. (a) FULL NAME

Katherine Elizabeth Zinkhan4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife none

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) April 14 18628. AGE: Years 86 Months 4 Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Belle Md.  
(Town, county, and state)10. Usual occupation none11. Industry or business none12. Name Adam Zinkhan13. Birthplace Germany14. Maiden name Susanna Bedesheim15. Birthplace Germany16. Informant Geo. P. Boettner (nephew)Address 2315 Prunial Ave.17. Burial Date thereof Aug 31 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BaltimoreLocation Belle Md.18. Funeral director Stewart & Mowen CompanyAddress 108 W. North Ave. City #119. Aug 30 48 G. W. Hedrick  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2315 Prunial Ave.  
(If rural, give LOCATION)2. (a) If veteran, name war none

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1948 at 5<sup>00</sup> A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 20 1948 to August 28 1948and that I last saw him/her alive on Aug 20 1948Immediate cause of death Cardiac failureDURATION 24 hrs.Due to Arteriosclerotic cardiovascular disease Unknown

Due to \_\_\_\_\_

Other conditions Hypertrophic aortic Unknown

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Stephen Lee Hagness MDAddress 752 Frederick Ave Date signed 8-28-48